

RAKKU'S STORY

**STRUCTURES OF ILL-HEALTH
AND THE SOURCE OF CHANGE**

SHEILA ZURBRIGG

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DEDICATION

This book is dedicated to the memory of two people:

To Irulayee of Pattam village, a young child who died amidst medical expertise, only because her family was too poor and unimportant. And to all children she represents.

And to John Maliekal, whose encouragement and support made this book a reality. His tragic early death in August 1981 prompts those who knew him to work with greater vigor, inspired by his thorough commitment to social action.

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Sheila Zurbrigg

Abbreviations

ANM	Auxiliary Nurse-Midwife
CHW	Community Health Worker
EPW	Economic and Political Weekly (journal)
ICMR	Indian Council of Medical Research
ICSSR	Indian Council of Social Science Research
IE	Indian Express (newspaper)
PHC	Primary Health Centre
WHO	World Health Organization

A Block refers to the smallest administrative unit of the rural areas, consisting of approximately 100 villages or a population of 100,00.

One lakh = 100,000

One crore = 10 million

One rupee = 100 paise (approximately US \$ 0.10)

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Introduction

This is a book about people in India who yet live in ill-health. It is an analysis of ill-health, but not the usual kind of analysis. For it begins by looking at people not by means of a stethoscope, but by looking at where and how they live.

The book is written in four parts. The first part, *Rakku's Story*, is the story of a village woman in southern India who tries to save the life of one of her children. Her story is not at all unique. It reflects the obstacles which confront most of the labouring poor who seek health care in rural India. The story is true, and is written in tribute to the people who live amidst such struggle and injustice. But it is also written in the belief that it is the only place to begin a useful analysis of ill-health in the country.

Rakku's Story is then used as a base and stepping-stone for a deeper understanding of the causes of ill-health and unnecessary mortality. And so the second part of this book is a closer look at this woman's life *in relation* to the rest of society, seeing how her life differs from that of women in India whose children do not die. The questions which her story raises lead the analysis step by step out from her thatched mud home, beyond her village, beyond even the hospital where she takes her dying child, to the very structures and nature of Indian society as a whole. From this perspective, poverty is seen both as the primary source of ill-health and as a force which renders the poor majority powerless to make effective use of the official health system, and powerless also to change it.

Part three of the study looks at the structure and assumptions of the existing Indian health care system, and its historical roots in the Western medical and social model. It examines the forces, economic and political, national and international, which continue to shape and legitimize a health system which is clearly inadequate and often inappropriate to the needs of the majority. In doing so, the analysis exposes the inherent limitations of liberal development theory which still today dominates both government and voluntary health activities in the country.

Finally, the fourth part of the analysis looks at the much broader social and political conditions which appear to be the foundation upon which significant health improvement can occur. This final section thus leads to specific proposals for change based on the primary need for collective pressure from the poor, as the only realistic starting point for a solution to the related problems of ill-health and social injustice.

Rakku's Story and its analysis are based on the experiences gathered during my own involvement in a rural health project in southern Tamil Nadu between 1975 and 1979. The successes and problems confronted by the women and men working in this village health programme, including the twenty-three women trained as "village health workers", are reflected in these pages. For those of us who were not villagers, these years taught us much about the realities of rural ill-health. We were surprised by the capacity of village women (many of whom were the traditional midwives of their villages) to provide basic health care to their communities. We were surprised to learn that the technical organization was neither costly nor difficult to establish. Yet in spite of major successes such as the reduction of deaths in young children by well over half, it became increasingly clear that even grassroots programmes possess very real *limits*. These limits lay not in health techniques, but in the underlying poverty of the majority of the village families and their social and economic powerlessness at the local and broader levels. And towards the end of these five years, the original project workers looked on in dismay as control of the programme was gradually taken away from the village people and came to be vested in the hands of outsiders whose interests were not primarily those of the rural poor. The resulting distortions of the project activities quickly brought the programme to a stop. What became sadly clear was that, while the health of the labouring families in these twenty-three villages had been improved for this short period, their dependency and powerlessness to confront established power structures in society had not changed.

Thus, the purpose of this book is to expose these more fundamental reasons for continuing ill-health — at the most basic level, the reasons for hunger, and the social structures which prevent access to adequate food (calories) by the poor, food which they themselves produce. This analysis attempts to return understanding of ill-health to a focus on poverty and the gross maldistribution of *all* resources and powers within Indian society, in the hope that these deeper issues cease to be obscured by the traditional excuses and white-washed over with patchwork health and development schemes.

While the initial chapters of this book look at specific problems within the health system, and at times, at the attitudes of particular professional groups, it does so not with the purpose of fault-finding or blaming of individuals within society, which is an insufficient and therefore unhelpful level of critique. It is indeed recognized that there are many individual health workers and officials who are working committedly and energetically for the common people. Rather, such a critical approach is taken in order to reveal the much deeper societal structures and forces which are believed to be the source of the specific inadequacies within the health system. In this sense, an analysis of ill-health and of the existing health system becomes a *window* on the socio-economic and political structures and forces operating in society.

The need for such deeper analysis takes on an even greater significance in the face of the current international interest in extending "primary health care" in the Third World. The motives behind this recent health interest unquestionably include genuine humanitarian concern. But this interest also reflects, among other things, a growing awareness by Western development agencies of the necessity of achieving minimum child health standards for "population control" strategies to be successful — in other words, it reflects motives and interests other than the apparent. One of the purposes of this analysis is therefore to reveal the inadequacy and indeed the risks of much of this primary-health-care effort, by showing how issues of health and socio-economic justice are concretely inseparable.

In beginning this analysis with the real struggle of one particular village woman the question arises as to how representative these observations from southern Tamil Nadu are for the rest of the country. Clearly, Rakku's life situation as an agricultural labourer differs in many ways from that of labouring families in other states. There will also be differences in the structuring and functioning of District hospitals or Primary Health Centres throughout the country — in fact, even within states. Yet it seems possible and valid to identify from this one woman's struggle, some general factors and barriers to adequate health which are *common* to labouring families throughout the country — questions and issues which only a description of the specific can reveal and draw out.

The analysis, then, is intended to encourage the readers, whether health workers or otherwise, to apply the questions which Rakku's story raises to the particular area or situation where they live and work. It is the *method* and *perspective* of the study, rather than the particular

details, which are offered as a way of understanding the more fundamental causes of continuing ill-health and unnecessary mortality in the country; and also as a method for considering what action has relevance in the broader national struggle for health and social justice.

And finally, though the analysis focuses on the Indian health and social system, it is clearly appreciated that the problems and contradictions looked at in these pages are in no way unique to India. The fundamental issues would apply to many, perhaps most, Third World countries (and indeed, to many Western countries) where the problems of health care inequality and inaccessibility continue to exist. In this sense, Rakku's story and its analysis are a contribution to the debunking, long-overdue, of the many myths which are yet used as excuses for continuing ill-health and social injustice in the world. It is within this broader perspective then that the story and analysis have been written.

PART I

Rakku's Story

Rakku's Story

It was an hour before dawn. Her infant son rolled against her in the tension of a momentary dream. Rakku* awoke in the darkness and rose noiselessly to begin the preparation for another day. Her husband was still asleep on the narrow verandah in the front of their small mud and thatch home. She slipped into the tiny yard behind, splashed her face with a tumbler of water from the earthen pot, then scooped a pinch of charcoal dust from the chola and began to clean her teeth.

It was early March. Already the day's heat was becoming oppressive as the summer months approached. As she cleaned her teeth with her finger, she looked up at the still sky and at the stars of Scorpio now almost overhead. The position of the stars reminded her that it would soon be the time of year of the goddess Mariamman, the powerful deity who brought the dreaded spots of Measles into the homes of young children. And she thought of her eleven month old son who a few moments before had been curled up at her side. With a deep sigh she promised the skies that before the same stars could appear again she would offer worship at the goddess' temple at the edge of the village. She rinsed her mouth of the charcoal, then swept back her frayed black hair and tied it in a knot at the back of her head. With a second tumbler of water in hand, she entered the room where her family was still sleeping and emerged through the front doorway. Walking through the narrow lanes of huts she reached the open fields beyond; it was a section of the dry brush fields used by the women for their toilet.

Her youngest child was whimpering sleepily when Rakku returned a few minutes later. As she lifted him up from the mat and swung him onto her hip, the child reached for his mother's breast under her still loosely tied bodice. It would be another half hour before dawn, time enough to pound the ragi for the evening porridge and sweep the house, before setting off to the well on the other side of the village. She tugged at Ponnu, her five year old daughter who was still fast asleep, scolding her softly to wash quickly so that she could fetch a few twigs for the morning fire.

* pronounced with a long "a", Rāhku.

The child rose from the dark room, and took the cup of water which her mother held out to her. She splashed her face and cleaned her teeth as her mother had done. Rakku took a plastic comb from the niche in the mud wall and beckoned to the girl to come and sit in her lap while she combed and braided her hair. As she tied the crumpled yellow ribbons Rakku explained to the child where, the day before, she had seen a few dry twigs by the path leading to the landowner Periaswamy's fields. Then she hurried her away to fetch the twigs for heating the porridge left over from the night before.

The sky beyond the compound was just beginning to brighten as she scooped the last handful of ragi grain into the hollow of the granite pounding stone. This was a woman's most tedious tasks. The more so now that her mother-in-law was no longer there to share the rhythmic motion of the heavy wooden pole. The old woman had died several years before, so now it was only Rakku's back that bent with each downward stroke of the pole, the rhythm shared between her two arms, while her free hand deftly pushed scattered grains back into the hollow of the stone. She missed the old woman's whispered chanting too — perhaps as much as her sharing of the labour. It was less comforting to sing alone — though she knew it must soothe her children in the last moments of their morning sleep, just as she had been comforted by her mother's song years before.

She set the ground ragi to soak, and began polishing the brass water pot with a mixture of earth and ash. She smiled faintly as she picked up the vessel. It was her most treasured possession — her family's gift to her at her marriage. Then, picking up an earthen pot as well, and a bucket tied with a long rope, she set out for the village well. Thoughts of the growing crowd of women gathering for water made her quicken her steps. But when she reached the well there were several women waiting, and the jostling for turn had already sharpened tempers. She looked around her at the women. Most of them were older grandmothers, too old for regular field work now, or young girls, some only slightly older than Ponnu. A relief, she thought to herself, when Ponnu would be strong enough to fetch the water for her in a year or two. It would spare her the landowner's scoldings whenever she reached the fields a few minutes late.

When her turn came she leaned over the low wall around the well, lowered the bucket and hoisted it up to rinse the two pots. The vessels were soon filled. She lifted the brass pot first and balanced it on her head, then shifted her back as the woman beside her helped place the second vessel on her hip. She turned slowly, steadying the pot with

her free hand. Her eyes met the woman's in a gesture of appreciation, and she started back down the lane. When she reached the house Rakku called out softly to Ponnu. The child took the pot from her mother's hip, excitedly, explaining to her how she had found three thick dry branches. A small fire was soon burning with twigs enough at least to warm the porridge. The first rays of sun were just coming over the low thatch fence from the narrow space between the huts behind.

Rakku could hear her husband, Karrupaiya, stirring. She heard him call for water, and sent Ponnu with a tumbler for him. Just then her eldest son Kannan emerged from the doorway, rubbing his sleepy eyes against the stream of morning sun that filtered through the smoke wafting from the chola. Kannan was a bright and mischievous child, and his energy and capacity for fun belied the frail frame of his body. Rakku smiled broadly. She loved this son, with the undiminishing relief and joy that all Indian women know who have been blessed with a son as their firstborn. The memory of his birth was as vivid now as it had been eight years before. But she remembered too that she should be annoyed with him this morning for forgetting to bring firewood the evening before. Truth to tell, the boy had gathered the usual bundle of twigs, but had set it down in the more exciting task of hiding one of his companion's cows behind the large bund out beyond the scrub pasture. When the cow had suddenly bolted, the sticks were abandoned in the heat of the pursuit. By the time Kannan had the cow under control again the sun had long since set, and the boy was forced to return home empty-handed, his friend teasing him mercilessly all the way. He had not told his mother the real reason for his empty arms but she had guessed such a story anyway.

Rakku picked up the straw broom from the corner and began to sweep the mud floor of the yard. Without stopping to look up at her son, she scolded him for his mischievous pranks. She did not dare look straight at the boy for she knew she wouldn't be able to restrain a smile at having discovered his pranks once again. The scolding over, Kannan looked hungrily into the earthen pot, knowing that he would have to wait for his share until his father returned from his morning visit to the fields.

Ponnu rolled up the frayed straw mat so that her mother could sweep the small room. Rakku swept a portion of the lane in front of the doorway as well, and there sprinkled some water. She asked Ponnu to bring the box of chalk powders and bending low to the dampened earth she pinched some of the white powder between her fingers, letting it slip through as she drew the traditional kolam design. Every

morning these delicate patterns appeared on the doorsteps of most of the village homes—a traditional sign of welcome to visitors and to the gods. The lace-like design would disappear soon enough under the footsteps of those who passed by, but the briefness of its beauty seemed unimportant.

As she bent to enter the house she noticed several gaping holes in the thatch overhang of the roof. It was unlikely that the thatch would last another season of winter rains and winds. But to replace the thatch was very costly. It was one of the regular expenses the poorer families dreaded. They had managed to save nothing this year, not even to replace Rakku's faded and oft-mended cotton sari. So they would have to borrow again from the moneylender if they were to have a roof over their heads next year. The thought of borrowing money again made her eyes close in a grimace — and she bent to enter the hut.

Her husband had just returned and was spreading the straw mat. Rakku gently pushed Kannan aside as she ladled a heaped plate of porridge and placed it in front of her husband. He took one of the remaining dried chillies from a small basket, crushed it between his fingers and carefully mixed a portion into each mouthful of porridge. When he had finished he looked up at Rakku. "Next week when the harvest is finished, we will have a meal of rice again".

She nodded, and added, "And maybe even a bowl of sambhar to celebrate the Chitrai festival next month".

After their father had finished, Ponnu and her brother took their places on the mat and plunged into the tasteless porridge with an enthusiasm imagined for the festival meal. Rakku scooped out the remaining porridge. Lifting up the plate with her right hand, and with the baby in her other arm, she sat down opposite the children. She loosened her blouse to let the child nurse in her lap while she quickly ate. She left a small portion on one side of the plate and told Ponnu to feed it to the baby at mid-day. And shaking her head she added, "For the baby, dear child, not for you". The small girl nodded, but her lips tightened as she turned away from her mother's look.

Karrupaiya had already left the house. He would stop at the local tea stall for a watery cup of coffee on his way to the landowner's fields. Kannan rose to wash his hand, and after drinking several tumblers of water left the house to collect the cattle he was to tend for the day. Since the age of seven he had been contributing to the family income by taking the cattle of several landowning families out to the scrub

pasture each day for grazing. The fields were about a kilometre from the village. But sometimes he would lead them along the embankments of the cultivated fields where a few green patches of grass grew, nourished by the moisture from the flooded or still damp plots of paddy field. The landowners knew that Kannan took good care of their animals and his earnings were a small but dependable part of the family's income.

Ever since the boy was born Rakku had dreamed of her son going to the village school to learn to read and write. But four years before, her husband was forced to sell their small piece of land and such dreams had vanished in the need for this son's earnings for the family. Each morning as she watched him leave, she would feel a twinge of this recurring regret.

The chatter of women passing through the lane reminded her that she was late for work. She quickly handed the baby to Ponnu, washed her hands and slipped out of the house. She was proud of her daughter too. Ponnu was just five but already she could be trusted to look after the home and the baby too. She thought with some pity of those women who had no choice but to lock their houses leaving their younger children unattended on the doorstep until evening. At least her own children had some family member to look after them during the day, if only young Ponnu for this fourth-born baby.

Rakku ran along the lanes, and past the high caste temple. She could see the other women running along the ridge leading out to Periasamy's fields. These fields were over a kilometre from the village — too far for the women to be able to return home at mid-day. And so some of them bore small pots of watery porridge on their heads for a mid-day meal. She followed the bend around the village tank. There was still a shallow patch of water in one corner. Two boys were washing buffaloes in the muddy water and playfully riding on the animals' backs. Kannan too would come here to wash the small herd he tended. The sun was already high enough to make the water seem invitingly cool. Rakku ran down the far side of the tank bund and on to the narrow embankment that separated the fields, and soon she had caught up with the rest of her companions.

The landowner's fields had produced a rich harvest this season. A few years before he had been able to install an irrigation pump with a loan from the government, and so for his section of the village land there was enough water to provide the regular irrigation which alone could ensure an abundant harvest. Work on his land was a precious source of employment for the women of landless families, and so to be



Women labourers harvesting rice, supervised by foreman

sure of being hired each harvest they had to make a special effort to be available for the entire harvesting. A few poor families who owned their own small patch of land were obligated to work the landowner's fields first. They could work on their own land only when his harvesting was completed. By the time the women reached the fields their limbs were already beaded with sweat. They spread out in the fields as the landowner's foreman shouted to them, took their sickles from where they had tucked them at their waists, and bent down to begin cutting the golden stalks of grain.

...As she reached for another handful of stalks, the ache in her back and shoulder suddenly made her arm go limp. Rakku dropped the sickle and slowly straightened up. It was late afternoon. Her breasts were heavy and sore from not having fed the baby since the morning. She took the end of her sari and wiped the rivulets of sweat from her face and neck. The sun was still piercing even though it had almost sunk to the tops of the coconut palms on the far embankment of the field. Muthummal, a neighbour and friend, was working further down the field. Rakku saw her wave her arm, signalling that they were ready to carry another load of the freshly cut sheaves. She bent down, gathered a bundle of them, and slowly balanced it on her head. She

bent again as the foreman placed a second load on top of the first. The sheaves of grain were so heavy now that she had to keep her spine rigidly straight to keep from losing her balance.

The sheaves drooped down on either side almost to her waist, and the straw hid her face. She could hear Muthummal running in her direction, but she could see only her feet and sari as she passed. Rakku turned slowly to follow, relieved now to be running in a slow gait, for the slight bounce of each step momentarily relieved her neck and spine of the pressure. Their short bursts of breathing sometimes would break into a measured chant as the women wound in procession between the patch work fields toward the village. The coarse stubble left behind in the fields scratched at Rakku's ankles but the soles of her feet were thickened since childhood to feel little.



BRINGING the harvest in — women bearing loads as large as men

Reaching the threshing ground at the village edge she saw her husband standing on top of the growing mound of straw, catching the threshed sheaves as they were tossed up to him and spreading them on the mound. It was a satisfying sight to see her husband with work, when for so many weeks and months there had been none. Perhaps in two or three more days they would finish the harvest on Periasamy's land, and return home with the precious measures of rice that were

their share for their labour. As was the custom the landowner would keep three-quarters of the harvested grain, leaving the remaining quarter for the labourers to divide up among themselves.

As each woman approached the threshing ground she would toss the load from her head, then return to the field one kilometre away for another load. It took them until the sun was enormous and orange-red on the horizon to bring in the remaining loads. Though bringing the grain in from the fields was exhausting labour, it was the work which brought most relief and a lightness of spirit among them. For in the unending struggle to feed their children or grandchildren such work meant security for another few months at least.

Walking back through the village with Muthummal and the other women, her arms and back felt numb with weariness. Yet she hurried through the lanes knowing that her youngest child would be crying for her breast. There was also the coarse millet to cook, and she had yet to visit the temple as she had vowed that morning.

Little Ponnu was waiting for her in the shadowed doorway with the baby crying and restless in her arms. Rakku reached out for the child and swinging him onto her hip became aware of the dampness of the cloth around the child. She turned to Ponnu, with a questioning expression on her face.

"Mummy, he's been having diarrhea all day. Each time I cleaned him and washed the cloths, more would come. When I tried to give him some porridge he would only vomit it out again"

Rakku said nothing but took the child to the yard behind, and flopped down on the ground under the thatch overhand. Leaning against the wall with the baby nursing hungrily she untucked the end of her sari from her waist, untied the small knot in the cloth edge, and took out a ten paise coin. It was the last coin she had. She put it in Ponnu's hand and closed the child's fingers around it, explaining carefully: "Go to the shop near the school and ask for five paise of the powder medicine for diarrhea. And watch carefully so that he gives you a full spoon of the medicine. Then buy five paise of the golden puja flowers from the flower stall just behind" And she patted her bottom to send her off.

The shadows of evening made it difficult to see the baby's face clearly, but she could feel a limpness in his body. She realized that the diarrhea must have been severe. Her head flopped back against the wall. How she dreaded the diarrhea disease in her young children! All mothers did. And she grimaced at the sudden memory of Muthummal's

youngest child dying a few months before. "No!" she said to herself, "this won't happen to my child!"

She gazed at the small child as he nursed, passing her fingers gently over his head and face, his limbs and stomach. As she lightly massaged his fingers and feet, she felt a sense of guilt that she had not been able to feed him more to give his body strength. But, strangely, as she sat gazing at the child, the feeling of guilt changed into a vague undefinable anger. Not for the child, nor for herself, but for the uncertainty of this child's life, and her own powerlessness to protect him.

The thoughts quickly passed as she heard Kannan entering the house. She called out to him, asking him to fetch a pot of water from the well. The boy protested, pleading that bringing water was a girl's job. If his friends saw him they would tease him cruelly. And besides, hadn't he brought such a splendid armload of twigs today?

"Kannan, the baby has diarrhea. He will need another wash. And I have much work to do. Please child, bring the water"

Ponnu returned with the medicine and flowers wrapped in bits of newspaper, and handed them to her mother. She brought the small sungoo cup* from inside the house and rinsed it with water as her mother asked her. Rakku took the cup from her daughter and gently pressed milk from her breast to half fill the tiny cup. Then she added the powder Ponnu had brought and put the open spout of the cup in the corner of the child's mouth as she coaxed him to drink. Each time the child swallowed, Rakku would massage his throat down to his chest.

When the cup was empty she handed the sleepy child to Ponnu, and with the flowers in hand she started off to the small altar-temple by the edge of their section of the village. She placed the three yellow marigolds at the base of the roughly hewn stone which had been smeared for generations with red sacred ash. Then she chanted the various names of the goddess Mariamman — as many as she could remember — turned and hurried back home.

When she reached the house, Ponnu was sitting in the corner of the yard on a flat smooth stone bathing the baby which was balanced on her outstretched legs. Many times she had seen her mother bathe the baby like this. She was sure she could do it herself now. Kannan had started to light the fire to boil the water for the porridge.

* the small traditional cup used for feeding infants in South India.

...They ate in silence that night. When he returned home Karupaiya had found his wife absorbed in her worry for the baby.

Throughout the night the diarrhea continued. The powder did not seem to have any effect. And Rakku spent the night cleaning the child and coaxing it to nurse. But by early morning she knew she would have to take the child for treatment. There was a doctor in the small town fifteen kilometres away. Once when Kannan had a severe infection this doctor's injection had cured him. But he had asked for a lot of money. Three rupees. And this time too they would have to borrow money. Such a thought! Her husband would not agree. It was impossible right now, for who would have any money to spare? Most families had already borrowed money, like themselves, to tide them over until the new grain was in. No one except the landowners and village moneylender could loan them money. But they charged such enormous sums, up to twenty-five paise a month for each rupee borrowed. Besides, how could she leave the field work now? If she did not go to the field the landowner would not give her a fair share for all her previous labour.

When her husband woke she knew he understood her desire to take the child to the town, and yet she hardly dared to ask. Instead she decided to take the child to the village midwife. At least Meena could tell how ill the child was, and often the herbs that she prepared did help, even for diarrhea in a child. So after her husband had eaten that morning, she took the infant to the midwife's house. But the house was empty except for Meena's mother-in-law. Without speaking the old stooped woman slowly gestured to Rakku that Meena had already gone off to the field work.

Rakku was still determined that the midwife should see her child. So she returned home and explained to Ponnu where she could find Meena, and told her to take the baby there for her advice. For by now Rakku would be very late reaching the fields. She hurriedly ate the porridge remaining in the pot and left the house, glancing back at the tiny whimpering baby in the arms of her five-year-old daughter.

...Sweat rolled down her back until the folds of her sari clung to her back and legs. The entire day she could not establish a rhythm to her work — her mind was far away, fixed on her youngest child. Her friends, unknowingly, teased her at first. The foreman scolded her bitterly as he stood the long day looking over the women's backs bending in the sun.

She did not wait for the others after bringing in the last load of grain

that day. When she reached home she found the child restless and crying, and it thirstily began to nurse. Finally, with its stomach full, it lay exhausted in Rakku's lap, only to vomit much of the milk a few moments later. She asked Ponnu to bring another cloth and listened as the girl repeated what Meena, the midwife, had said that morning. "She asked you to come before the evening meal. She wants to give him some herb medicine. Mama, she says you must come".

The sun had just set when Rakku reached the midwife's home. The older woman instinctively reached out to feel the baby's head. Her fingers gently passed over the soft fontanelle. She looked up at Rakku. "The dryness has started, Rakku. The diarrhea is severe. Come, bring some poduthavai leaves, and I will make a herbal medicine". And she explained to Rakku where the special leaves were growing.

Meena had been the village midwife for many years. She was illiterate as were most of the low caste women in the village. But she had learned her skills from her mother-in-law who had been the midwife before her. She was a grandmother now, perhaps in her midforties, though like most of the villagers she wouldn't have known her exact age. Her husband's family was poor, but because of her long experience in caring for the mothers and small children in the village most of the women, even among the higher castes, trusted and respected her advice. And she cared for the women of the untouchable families with as much concern as for the caste families. She was a strong woman, though thin, and her face showed the lines of having laboured many years in the fields.

Rakku returned with the leaves within a few minutes. The midwife took a piece of turmeric root and some other leaves from a shelf and kneeling in front of the granite grinding stone, ground them together. As she rolled the stone she would gather the mixture together with the side of her palm and small finger, bringing it again to the centre of the block. When the herbs were ground smooth she scooped the dry paste into the palm of her hand. Rakku unfolded the corner of her sari and tied the paste within it.

The midwife explained, "Give this tonight and again in the morning". Then added, "It is said that a child with diarrhea should be starved, but Rakku, I never stopped breastfeeding my own children, even when they had diarrhea. And though I have given these herbs, if he were my child I would also take him to the town doctor. If you go quickly there is still time enough to catch the bus from Palayanoor village". But she knew enough to ask, "Will your husband give you permission?"

Rakku shifted the child onto her other hip in awkward silence. The midwife understood. It was the same for most of the landless families. Keeping spare rupees in one's hand was like trying to hold water in sand. "Let us see", she said at last. She was untying the knot in her sari edge, and from it took a crumpled rupee note and put it into Rakku's hand, saying, "There was a delivery in the next village last night — a son, first-born. So they gave me a rupee. When you are earning daily wages again you can return it to me then". Rakku nodded and went out, promising to herself that she would bring Meena a measure of rice when she had received her share of the harvest.

Her husband said nothing when Rakku told him of the midwife's suggestion. She knew that he was silently asking how he could let his wife go off alone at night. And from whom could they borrow four or five rupees for the injection and bus fare? She dreaded his response of silence. She couldn't reply to that. So she stood motionless, as the flickering light from the kerosene wick cast shadows across her face and the child in her arms. Finally she went out into the yard behind.

She heard him leave the house, and when he returned some minutes later he quietly called to her. "Come, we must run if we are to catch the Palayanoor bus". Rakku grabbed the rags from the thatch fence which Ponnu had washed a short while before. They were still damp. She called out to Kannan and Ponnu that they would bring back a parcel of rice cakes from the town. And they set out, Rakku running to keep up with her husband.

Palayanoor village was only a kilometre away, but the path was narrow and deeply rutted by bullock carts. The last light of dusk had faded. If she looked up for even a moment she would break her gait by stumbling over the hardened mud. The child on her hip was so limp now that she had to cling to him with both her arms.

...As soon as the doctor heard the word "diarrhea" he reached to a table behind and took a syringe and needle from a basin. A small pot was simmering on a kerosene burner nearby. Rakku rubbed the infant's buttock instinctively after the injection, while her husband handed the man three rupees — a note and a jangle of coins. He was the local "doctor", though he had no training except what he had learned from watching his uncle for many years. But the villagers liked to go to him even though he charged, because he always had an injection to give, and he did not speak roughly, or talk down to them. It was true there was a government dispensary only a dozen shops down

the road, but it was not open in the late evenings when the villagers could reach it. And as often as not, the government dispensary would run out of medicines, or would be handing out the same yellow pills for everything. Besides, they had heard that though it was "free", patients often had to put some coins in the clerk's hand to be seen. And the doctor was young, and often spoke harshly.

The "doctor" listed a number of foods that the child should not be given. "And mother's milk". Rakku asked. He raised his eyebrows. "Many say not to give even mother's milk", he replied.

They squeezed out of the tiny "dispensary" through the two rows of people still waiting to be seen. With the left-over change Karrupaiya bought two packets of steamed rice cakes from one of the stalls by the bus stand. He ate from one packet as they waited for the last bus back to Palayanoor. Though she was aware of the hunger in her stomach, Rakku did not eat. Only after her two children had eaten would she take anything that remained from the second packet.

The stars of Orion had swung fully up into the sky as they left Palayanoor village and began their walk home. The child was sound asleep in her arms and indeed the diarrhea had stopped. The medicine the "injectionist" had given had been a standard mixture of sedative and aspirin-like drug. It took away the fever and restlessness, and often calmed the gastroenteritis of young children — at least for a while. The change seemed dramatic and it impressed village mothers. And for the majority of childhood fevers this treatment was enough. They did not know that the same drugs could be bought as tablets for a fraction of the cost.

The village lanes were dark and quiet when they reached Puliangulam. And as wordlessly as the entire journey had been, they made their way to their own small hut. Rakku woke Kannan and Ponnu and gave them the packet of rice cakes.

It was almost morning when the infant finally awoke from its sedated sleep. In spite of the injectionist's words Rakku let the thirsty child nurse. She remembered Meena's words, and trusted them more. By mid-morning, long after Rakku had gone to the field work, the sedation from the injection had worn off, and the diarrhea began again. That evening Ponnu handed the baby, now quite limp, to her mother as she entered the yard. A visit to the midwife confirmed that the dryness was worse and that Meena feared for the child's life. Reluctantly she told Rakku the stories she knew of diarrhea children being cured with "glucose water" injections at the big hospital in the city.

Rakku laughed pathetically at the mention of the city. "Meena don't plague me with such talk. The city is forty kilometres away. Where would we get the bus fare to make such a journey? And who could possibly spare a day to go? It hurts me to hear you speak like that!"

The older woman understood, and said no more. Yet it was clear that treatment at the city hospital was the only hope she held for the child. She also knew that the anger in Rakku's words was not directed against her, but against the binding helplessness of her situation.

Rarely in her life had Rakku wept openly. Such emotion was not accepted within the village communities, and so women developed a strong resistance against showing their despair and sadness. But tonight was different. Tears filled her eyes as she walked back to her home. In her mind she relived a similar struggle to save her third child, and the pain of its death a week after its birth. Yet the pain was just as intense for this child—even more so.

When she reached home she said nothing to her husband. Not until their evening meal was finished did Rakku find the courage to tell him of Meena's suggestion. This time there was no silence. She stood passively, leaning slightly against the wall. Of course she could understand all that he was saying. How could they borrow more money now, except by adding to their debt to the moneylender? How could she leave the field work now, without losing her precious share of the harvest? And finally how could she, a woman, go alone to the city?... Turning away from his wife, Karrupaiya added, "Haven't the gods taken our second son? Must they not decide for this son also"? It seemed that he added this not because he believed it, but in a desperate effort to relieve the anguish of the other unanswered questions.

Strangely, in a way she did not understand, Rakku felt an even stronger urge to fight for this child. There was something that would not allow her to accept his death. Perhaps the grief for her other child was still too sharp? And yet, was one death not supposed to steel a woman to another child's death?... It may have been partly because of Meena's advice. She had come to know and trust her ever since she had first been brought to this village as a young bride. But it was also anger that stirred in her. Anger for what?... She wouldn't have been able to say exactly, though she well knew that there were some village mothers who could afford to take their children for treatment when they needed it.

Facing her husband, Rakku found herself suddenly filled with the courage to say: "No, let me try. Let me go to the city and see. Though the landowner will cut my portion of the grain unfairly, with what remains I can pay back the rupees we have borrowed. I shall even sell the brass vessel if that is the only way to keep us from starving".

She had never spoken like this to her husband before. She was as surprised as she was afraid. And though he continued to argue, Karrupaiya had already been swayed by his own love for the child and the display of his wife's love. They both knew the precarious balance that kept the family from hunger — and the extreme limitations it put on meeting the needs of individual members. The dividing line between poverty and absolute destitution was so fine, that to give an extra bit of attention to a single child could easily upset the balance. And yet it was equally true that each child was an important source of security for the family. The death of a male child especially was an absolute loss to the family. And so it was that both out of love and need for this son, Karrupaiya at last agreed to let his wife take the child to the city.

The following morning Rakku climbed into the early morning bus from Palayanoor with a borrowed five rupee note tied in her sari. The money had been begged from the village moneylender and it had to be repaid in paddy when their small portion of the harvest would be in, plus an interest worth almost one third of the amount.

She had been to the city only once before — as a young girl, in celebration of the summer Chitrai festival. Then she had been surrounded by her family as she rode in their bullock cart. Could it be ten, fifteen years before?... she wondered.

The road was deeply rutted and wound around the wide bunds which collected the precious December rains. The road had once been thinly asphalted, but there was so little of the asphalt left now that what remained was only an obstacle for the buses' wheels. The land alternated between long stretches of dry treeless scrub and pockets of lush green fields of rice or sugar cane where the water table was high enough to allow for irrigation. The bus driver blared his horn as they passed groups of women on their way to work these fields of paddy harvest. Some of the women ran along the roadside in lines, some balancing small vessels of watery porridge on their heads for mid-day, and a few, walking with the exaggerated gait of pregnancy.

Rakku was scarcely aware of the scenes they passed. Her half absent gaze was fixed on the child in her lap. She draped the folds of

her sari to cover the child as she held him to her breast. But the child had only enough strength to nurse for a few moments at a time. Its body was now quite limp and dry.

The bus eventually reached the small town where they had come two nights before. From here she would take a second bus which plied the main road twenty kilometres into the city. She shyly asked a woman where she could catch a bus to the city. The woman's husband pointed to several tea stalls down the road. She walked over to where the man had pointed and waited there in the sun. Suddenly she recognized a woman dressed in a white cotton sari getting down from a bus that had just come from the city. The woman's hair was neatly pinned into a bun at the back and her sari was starched and draped neatly in pleats. It was a government sari and identified the woman as one of the staff from the rural health centre of the Block. She was an Auxiliary-Nurse Midwife.

Rakku had seen the woman in her own village over a year before. She had been seven or eight months pregnant with the child she now held. It was by accident that Rakku had been home that day. She had started to bleed a little that morning soon after reaching the scrub fields to cut firewood, and had returned early to the house. As she reached the doorway of her home she had heard someone calling out to her, and turned to see this white sari woman following her. The woman was carrying a large black umbrella to shade her face from the sun.

The nurse-midwife had begun to tell Rakku that she could give her an injection which would protect her newborn child from dying of the "seventh day disease", which meant tetanus of the newborn. But she also asked Rakku how many children she had. When Rakku told her that two of her three children were alive, the woman began to talk of the Family Planning operation, and asked how she could feed and educate more than three children.

Rakku was embarrassed to talk about such things, and astounded too that the woman would think that a family needed only two or three children. In her confusion and shame she had turned away and walked into the house, refusing the injection. That night she had sat thinking how strange it was for a city-minded woman to be talking of such things. How little she must understand of village life. But she realized that for a steady government income a person might be willing to talk about anything. It was true she had heard that several health centre workers would often come by bus to Palayanoor village. And several cousins there used to talk of how they were afraid of the "immunization" injections, thinking they might really be "Family

Planning" injections. But it was unusual for these health workers to meet the women of poorer families because they would only reach the village late in the mornings, long after the majority of village people had gone off to do the field work. And besides, it seemed that her village was spared many such visits because it was not on a bus route and many of the workers did not care to walk the distance.

All of this passed through her mind as she watched the woman cross the crowded road and board the bus from which Rakku had just got down. She shifted the child in her arms and covered its face from the burning sun with a fold of her sari. As she watched the bus start, she suddenly felt resentment towards this woman. She wondered why as a health worker she did not have medicines for helping sick children. Why did she only have injections for healthy children and advice to mothers to stop having more children! Here was her child dying and this woman could not help her.

The bus to the city soon arrived. It was almost full. She was shaken by the crowd pushing to get on, but the conductor managed to find a seat for her, seeing that she was carrying a child.

The towns and villages they now passed were larger and completely strange to her. She was suddenly seized with fear at the thought of her child dying away from her village amidst strangers. During the entire journey she found herself alternately cursing her rashness in coming, and hoping that the big hospital's treatment might save her child.

The bus was so crowded as they approached the city that she could barely see outside. The noise of vehicles and the slower speed of the bus as it wound around people, cycles and bullock carts, made her aware that they were entering the city. The intensity of the noise—the roaring of trucks and buses with their horns blaring, and the jarring music from the loudspeakers of cinema houses, filled her with confusion. She began to dread the moment when the bus would finally stop and she would have to step out alone.

When at last they reached the main bus stand in the centre of the city she waited until all the other passengers had scrambled out before getting up. Outside, she could see many other buses, entering and leaving, and masses of people crowding for tickets and seats. She followed a group of village-dressed women who seemed to know the direction out of the station, but could not keep up with them. In desperation she stopped beside a flower stall to get out of the jostling stream of people. Behind the bench laden with jasmine flowers, a young girl was quietly stringing the tiny white flowers into garlands.

Rakku watched her for a few moments, and then hesitatingly asked the child how she could get to the government hospital. Without breaking the rhythm of her work, the girl looked up. She nodded to an intersection outside the bus stand, and said that the hospital was several kilometres across the city. She told Rakku to cross the street and to take a number three bus.

Rakku nodded slightly, turned and walked out into the street. There was a continual stream of buses, trucks and cars, and a policeman trying to direct the traffic. The crowds of people were so great that at intervals they would finally force the traffic to stop to allow them to cross. She could see several painted buses on the other side. She edged her way over and was able to recognize a number "3" on one of the buses. But it was already full, and she had to wait for a second bus. When it came she climbed inside behind a group of other women, though this time she was not able to find a seat. Rakku asked a woman seated beside her if the bus would go to the large hospital and the woman nodded. "And how much is the ticket?" Rakku asked. "Thirty paise, ammah", she told her. Rakku took the coins from her sari with her free arm and handed them to the conductor as he pushed his way through the standing crowd of passengers.

The woman offered to hold Rakku's baby, but Rakku explained that the child was very sick and so she only should hold it. The woman nodded and said she would tell her when they reached the hospital. She was getting down at the same stop.

Rakku was glad to have taken the local bus, for the journey through the city was indeed several kilometres. Each time that the bus stopped she was pushed along in the aisle as passengers climbed in and out. Eventually the bus swung through a half circle and came to stop opposite a massive grey stone building. Most of the passengers were getting down here and she soon realized that this must be the hospital stop. She pushed her way down from the bus along with the large group of other people and followed them past the rows of vendors' stalls, selling everything from fruit to empty bottles for holding medicines.

As she approached the front of the hospital she realized that the entrance was closed off by enormous iron gates around which a small crowd had gathered. Most of the group were as poorly dressed as she, and many were women. This gave her courage enough to ask one of the women standing close by why the gates were closed. The woman turned to Rakku in surprise. "Don't you know? The gates are always closed by nine each morning. If you want to have treatment you must

come by seven or eight." And she clicked her tongue to the roof of her mouth, in pity, "Cch! You are from the village!"

"But it's not for me that I've come. It's for my child", Rakku protested. A pitying smile came to the woman's face. "Try and see then", she said. "If you are lucky he may let you in, but only with a rupee note slipped into his hand"

The man guarding the gate did let her through — for the price of a rupee note. Her anger at the thought of the rupee representing almost a day's wage for her would have made her curse the fellow as she passed. But her mind was pre-occupied with her child, and overwhelmed and confused by the strangeness of what surrounded her.

The yard in front of the main entrance to the hospital was filled with people, some carrying containers of food bought from outside for a sick relative. There were some white-sari'd women too, and Rakku realized that they must be nurses. She followed two of the nurses through the main entrance and tried to draw their attention. One of the young women turned to give Rakku a half glance, but continued walking with her friend. Rakku stopped and leaned against the wall bewildered. With another forced burst of courage she finally walked up to another white-sari'd woman coming down the hall.

"Sister, my child is sick. Please, who will see him?" The woman looked at her in surprise, saying, "The out-patients' clinic is closed now. Why didn't you bring him earlier? You must come back tomorrow morning by seven". And she turned to continue on her way.

"But my child is very sick and weak", Rakku protested. The young nurse stopped impatiently. "Very well then, go to ward number one-fourteen, down the hall and to the left. Someone may see the child there". And she rushed off.

"One-fourteen"; Rakku repeated to herself to keep from forgetting. She walked down the hall and turned down the left side. The halls were lined on both sides with patients and relatives sitting, leaning against the walls, some with bandages, and most, dazed and quiet. She saw numbered signs above some of the doors but she could not read them to be sure and felt ashamed at having to ask. But she did ask. A few people thought they knew and sent her running down a maze of halls. Eventually, in near despair, she reached the children's ward, and once inside felt courage enough to approach another nurse. This woman pointed to an unseen room at the end of the hall, telling Rakku to go there and wait. A doctor would come soon.

The ward was filled with people. Mothers with children in their arms or over their shoulders. Some women sat against the walls of the hall, holding emaciated infants that were sucking on bottles of watery milk. Others were standing and trying unsuccessfully to get out of the way of the nurses as they hurried from room to room. She passed three large rooms with rows of iron cribs on both sides and rows of straw mats on the floor between the beds. Each cot and bed held at least one child with its mother or grandmother at its side. There was hardly walking room between them. Almost all the children were quiet and still. Most looked very ill. The third room contained only tables which were covered with sheets of rust-coloured rubber. Children were lying in rows on these tables, each with a bandage around an arm or leg, with a clear thin tube connecting the bandage to a bottle of water suspended above from a pole. She noticed the smell of feces, but much stronger, a biting sharp smell that reminded her of the odour from the village well water after a government worker had once thrown some white powder into it.

A nurse brushed past her into the room, then turned and scolded her for blocking the way. She walked ahead and stood just inside the room which the first nurse had gestured to.

A few minutes later another woman carrying a slightly older child joined her in the small windowless room. Silently they stood waiting together. Groups of men and women would occasionally pass by in the hall. They were wearing white jackets and carrying stethoscopes in their pockets or around their necks. The women, some of them very young, wore saris of thick soft silk or fine synthetic material. They had beautiful shining hair braided down their backs. They would be chattering and laughing as they walked by, unless they were accompanying an older doctor.

...Perhaps it was only half an hour — it seemed agonizingly longer — when a young man, also wearing a white jacket, came into the room, sat down at the small corner desk and brusquely beckoned to Rakku with a wave of his hand. She bent low to show him the child that lay unconscious in her arms. Without speaking a word he looked at the baby's lips and pinched the skin over its stomach several times. The child squirmed. He quickly listened to the child's chest and abdomen with his stethoscope, and without looking up at Rakku asked if there had been blood or large worms in the child's diarrhea, and how long the child had diarrhea. When Rakku replied to his last question he looked up impatiently, saying, "Three days you waited to get treatment for the child? Look at the dehydration!", and he pinched

the child's skin again to show her the dryness.

Rakku did not reply. For the only answer was her poverty, and how could she explain that to him? How could she explain what it meant to her family to be missing the field work even for a single day? How could she explain that the money borrowed for the journey would be paid back from their small store of grain which was already far too meagre for the family? Most of all how could she explain how important this child was to her and to her family? She was deeply wounded by his unspoken conclusion that she did not care for the child, but she bowed her head and said nothing.

The young doctor rose from behind the desk and beckoned again with his hand for her to follow. It was to the third room he led her, and then he disappeared. After another ten minutes he returned, followed by a nurse. Rakku laid the child down on the edge of the table as they told her to do. As they had done for the other children, they placed a needle into a vein in his leg and connected it to the "Glucose water" bottle above. And like the other mothers in the room she stood holding the bandaged limb to keep the needle straight as the water slowly began to drip life back into the flaccid body of the child.

The hours passed. She wondered how long the treatment would take. She had promised her husband to return by the evening bus. The nurse came back several times during the afternoon to check the needle and ask each mother if the diarrhea still continued, and if the child had passed urine yet. A second bottle of water was started for Rakku's child. By the late afternoon she realized that she would not be able to reach the town to catch the last village bus. Karrupaiya would be enraged and ashamed that his wife was staying alone in the city overnight. She was torn between her obligation to her family and husband, and to this child. Looking at the other children, she could see that they were slowly becoming stronger with the glucose water, and she desperately hoped that it might be the same for her child too. In fear and confusion she somehow made the decision to stay, almost in disbelief at her courage to do so. It was perhaps the first decision she had ever made on her own.

By evening some strength had returned to the child's body. The diarrhea had stopped and late that night the nurse removed the needle from the baby's leg. The nurse told Rakku that she should wait until the morning, and if there was still no diarrhea she could be sent home. Rakku asked anxiously, "What if the diarrhea returns? Can you give some tablets or an injection?" But by this time, the nurse was off checking several of the newly admitted children.

Early the next morning the child was discharged. Another young doctor had looked at the baby. Rakku was about to explain that some diarrhea had started again during the night but the nurse reported none. They seemed sure that it was not significant, adding, "Besides, mother, there will be another batch of children coming in very soon from the morning clinic and they will be needing the glucose water" And they turned to the next table.

The child was indeed better. It had strength now to nurse and to cry. She wrapped him in the still damp cloth and made her way out of the long corridors of the hospital. Once out on the open street she became aware of her hunger and she remembered that she had not eaten since two evenings before. There were coins enough for two small rice cakes if she walked back to the bus stand instead of taking the town bus. Her shyness in walking alone into a food stall and then asking for directions to the bus stand was almost as painful as her stomach's emptiness. As she walked through the crowded narrow city streets the lorries and shining cars passed with such speed that there was no way to avoid the dust and exhaust which rose in clouds.

But the journey back to her village was as full of despair as the journey into the city had been frightening the day before. The child's diarrhea had started again — the watery diarrhea so common in under-nourished children when their bodies and stomachs are too weak to absorb the food they are given. It was the chronic diarrhea of mal-nutrition. Rakku did not understand this, at least not completely. She half believed that the child had been cursed by an evil spirit — a belief that was common in her village. But she also knew that the reason the child's arms and thighs were so thin was because she had never been able to feed him during the long hours of the day — even to breastfeed enough. For scarcely a month after the child's birth she had to return to the field work. She knew all this and it burned inside her, yet she dared not dream of any other way. Every poor mother faced the same problems. Did that not make it inevitable and therefore acceptable?

The sun was directly overhead as she climbed down from the village bus and started the walk back to her village. Only as she reached the open fields could she admit to herself the weariness she felt from not having slept for the previous three nights, and the weariness from a renewed fear for the child. It was this physical and emotional fatigue that numbed her against her husband's scolding that evening. Even before he reached home, Meena had come to see the child and hear the long story. The midwife looked at the bandaged ankle where the needle had been and at the still dry lips. Finally she looked up. "Let us

see by morning, Rakku," she said, and paused. "Let us see by morning".

As she turned to go there was a passing moment of awkwardness that betrayed her doubt. She went out hurriedly, leaving Rakku alone to face the work of pounding the ragi. When her work was done, and the porridge was simmering on the fire, Rakku sat down, leaning her head back against the mud wall. In the growing dimness of the evening, she kept gazing at the child in her lap. As she watched the child's face, a sense of impending death filled her heart. And the agony of this absorbed her thoughts completely. When her husband returned, his scolding was as much from his helplessness at seeing his wife's despair as it was from his anger and shame at her having disobeyed him. She served him his meal, then gave the children theirs.

That night while her husband and two children slept under the thatch roof Rakku sat behind in the yard and silently rocked the tiny dehydrated body of her dying child. By early morning there was no life left at all. She continued rocking the baby, clutched even more firmly in her arms, and softly began to sing a death lament.

Her husband awoke — he had never really been asleep. The low pitched wailing stunned him for a moment, even though he had been expecting it through the night. He rose and walked out into the pathway toward the house of the caste priest. By late morning the child was buried — Karrupaiya had been forced to take the tiny lifeless body from his wife's arms. Because it was the death of a young child they did not perform the elaborate purifying rites required for adult deaths. Even so their mourning filled the small mud home for many weeks.

They continued with the harvest work, but Rakku worked mechanically, and often out of rhythm from the other women beside her in the field. They understood, for they too had seen their children snatched away by death. And so they all shared the depth of her helplessness and pain — as they bent together in the burning fields cutting the sheaves of grain that only in small measure were to be theirs at all.

And the question which anger had pushed forward into Rakku's consciousness would eventually slip away again with the overriding ache in her arms and back as she continued the daily struggle of her life. It would be forgotten... until perhaps the death of another child.

PART II

A Village View of Ill-health

Introduction

What does the drama of Rakku's child's death represent? Is this woman's struggle simply an unfortunate and isolated story?... Not at all. The barriers which Rakku faced in trying to save her child are in essence shared by many, perhaps most, of the five million other families each year who lose young children. The only unusual aspect of Rakku's struggle is that she sought to come closer to using the official health care system. Most villagers do not; indeed, cannot, through poverty and a sense of alienation from that system.

Why should the existing health system hold so little meaning for this woman and her child, when the national government has channeled, since Independence, enormous resources and planning into health services? Among Third World countries India is one of the most fortunate in terms of medical training and expertise. One hundred and six medical colleges are graduating 11,000 doctors every year. The government has set up a rural health system through a network of 5,400 Primary Health Centres¹, and all services are available free of cost. District hospitals provide curative and referral services which are also free to the urban and rural people using them. A multitude of private medical stores throughout the country make available the entire spectrum of modern drugs. And what is more, the Indian government actively supports and promotes several highly developed indigenous systems of traditional medicine. So what is wrong? Why does such a fundamental contradiction exist between available 'expertise' and continuing ill-health and high mortality rates among the people?

In India various national and international experts have been looking at these questions over the last several decades, puzzled, frustrated, determined to make the system more effective in reaching the health needs of the people. As a result, a series of new health schemes and approaches have been devised, 'chalked out', grandly inaugurated, and implemented one after another — each subsequent scheme hailed as the answer to the shortcoming of its predecessor.

But what stands out as missing from all these efforts is a deeper analysis, *from the villagers' point of view*, of why the existing system continues to remain out of their reach. Instead, various attitudes, which can be termed myths or ideology, dominate official thinking—superficial explanations for the underutilization of health services, such as the ignorance and stubbornness of the rural poor, or their tenacious beliefs in backward attitudes towards disease. Or even the assumption strongly fostered by Western international agencies and councils that Third World populations are poor and ill because they insist on having too many children.

It is curious indeed that the planners rarely have looked at the reasons for the failures from the perspective and reality of the village poor. This is so perhaps because the planners' short-term positions, either as political figures or international agency consultants, prevent them from having the essential depth of perspective on the working of previous schemes to be asking the most critical questions. It can also be argued that, for many of the advisors and planners, their own positions within the existing social system or agency make them, by definition, reluctant to be looking at the deeper structural questions.

This second part of the study seeks to expose the barriers, from Rakku's point of view, which prevent her from saving the life of her child. An understanding of the economic and social reality of her village life leads to an interpretation which is quite different from official explanations and assumptions. In pursuing this village-understanding, we will look more closely at the daily life of Rakku as an agricultural labourer, and consider the implications of her family's poverty for their health and their ability to make use of health care services. Further chapters will broaden the analysis to examine the health priorities of the rural majority as a whole, and assess to what degree the health system is organized to respond to these needs. We will consider, as well, the ways in which the structuring of health services itself compounds the problem of inaccessibility for the rural poor.

In other words, this part of the study places Rakku's struggle in the context of the daily struggle of the poor against hunger.

Note

1. *Sixth Five Year Plan, 1980-1985*. Planning Commission, Government of India, New Delhi, 1981, p. 366.

CHAPTER I

The Economic Base of Ill-Health

In order to understand the constraints which limit Rakku's choices of action to save her child, it is essential to understand the social and economic base of her life. This chapter therefore gives a more detailed picture of village life for the labouring poor than was possible to portray in the narration of her story.

1. Economics for the Labouring Village Family

Rakku, twenty-seven years of age, is the mother of three children in a village in southern India. She belongs to the village 'Untouchable' community, but in her poverty, could belong to any of the lower castes in the village. While her poverty is not the exclusive 'right' of the Untouchable community, the proportion of Untouchable families, landless and living in absolute poverty, is far greater than for most other castes.¹

At the age of fifteen Rakku was married to a man seven years older than herself. At the time of her marriage her husband owned half an acre of dry land, but was forced to sell it to pay back the debts incurred during a severe drought some years later. Now Rakku and her husband work solely for daily wages on the land of the larger landowning families in the village. Their daily-wages life is typical of most of the landless or minimally-landed families of rural India who together represent at least half of the total rural population.²

Because this part of Tamil Nadu is mostly dry land, depending mainly on rainfall rather than on irrigation, there is usually only a single major harvest in the year. If the summer rains are good the planting of a second crop is sometimes possible, usually a coarse millet, such as ragi, the staple food for most labouring families because it is cheaper than rice.

The field preparation, planting, weeding, and harvesting of these crops provide somewhat regular work for Rakku for three to four months a year, and sporadic work for her husband. Certain types of agricultural work are reserved for men, traditionally the ploughing of

fields and preparation of the terraced earth borders which separate the fields. The remaining work of transplanting the young paddy shoots, regular weeding, much of the harvesting, and the parboiling of the harvested paddy before milling, are done mainly by women. According to custom, the landowners need pay women only half to three-quarters the daily wage paid to men. This is so even though these tasks require more precision than strength and therefore women are as 'productive' as men doing the same work. In Rakku's village in 1981 the average daily wage for men was between four and five rupees; for women, two to three rupees. Traditionally too, the types of agricultural labour generally reserved for women are the more 'back-bending' jobs. Scenes of planting, weeding, and harvesting are scenes of women in the fields, their bodies bent down from the waist from morning to dusk. Such work is considered less dignified for a male, though many men from the poorest of families do participate in the harvesting.¹

For the remaining eight to nine months of the year, work is sporadic and a constant struggle to obtain. Rakku and her husband often work gathering firewood. Large tracts of this District are dry and unproductive except for growing scrub bush which the labouring families trim to sell as firewood in the neighbouring towns and larger cities. The landowners lease portions of this land to the labourers. Various local construction jobs occasionally provide a few extra days labour. Any work, even the most meagerly paying, like collecting twigs or bits of grass growing by the roadsides, is eagerly taken up in the constant search for income. *For to work is to eat.*

When Rakku's husband still owned half an acre of land, Rakku would carefully plant part of it with vegetables — as much as she could bring water to each day. She would sell the beans, okra and brinjals which she grew, in the market place each afternoon. They would plant the remaining portion of land with ragi which would provide enough food to last the family for one or two extra months. This land was gone now but at least Kannan, her eldest child, is old enough to be contributing in a small but important way to the family's income, by herding the landowner's cattle. For his labour the landowner gives him one meal of porridge each day, plus two rupees a month for each animal he looks after.²

2. The Economic Contribution of Children

In this, and many other parts of the country, children of the village landless become at a very young age essential for the earning power of

the family. Some children, like Rakku's son, directly contribute by herding cattle for the wealthier families in the village, or by collecting bits of firewood. Young girls often contribute indirectly, as in the case of Rakku's daughter who, at the age of five, is already beginning to take over much of her mother's household work, thereby freeing her mother for the daily field work. Perhaps the most important role for young girls, four to ten years old, is looking after their younger brothers and sisters. But they also fetch water and help to grind the coarse millet for the daily meal, both time-consuming jobs.

A third economic value of children is their labour potential in cottage, or small-scale industries. Throughout the towns situated in rural areas, labour-intensive industries have developed which employ significant numbers of young children. In Rakku's district such local industries include fireworks and matchmaking industries which employ children between the ages of six and twelve or thirteen years. The children usually work from dawn to sunset and are paid "children's wages", that is, 50 paise to a few rupees per day depending on their work. In some areas company trucks or old buses pick up the children from the surrounding villages well before daybreak and deposit them back in the evening.³ Estimates are that there are almost eleven million young child labourers in the country. Conditions of work for these children are difficult and often entirely wretched.

For over half the village families, sending children to school is entirely out of reach economically — not because the village schools are costly, for primary education technically is "free". But rather, because most landless families cannot afford even a single non-producing family member. At present, only 25% of all Indian children complete primary school.⁴ The widely advertised Family Planning motivation — that a small number of children allows a family to better provide for them, including education, remains fantasy for the poor. It reflects the enormous gap which exists between the government and elite of the country and the economic reality within which the rest of the population lives*. As a neighbour in Rakku's village explained,

* This does not mean that economics is the entire explanation for low school attendance rates for children of the poor; or by implication, that extension of primary education must wait until poverty is eradicated. Primary education could be structured so as to provide classes in the evenings when children are available, reflecting the constraints of labouring families. Furthermore, there is another contributing reason for low attendance. For children of low caste and labouring families, school can often be an unpleasant experience because of harsh and degrading treatment from village teachers and other children. This only compounds the economic barrier faced by the poor.

"To educate one, we need four to support him!" And she added, "Education is useful for keeping accounts but useless for jobs".

The daily earnings of children are thus extremely important for poor families — earnings which often amount to what it costs the family to feed them. As soon as the children reach their early teens, they can moreover perform the heavier but more 'lucrative' field work.

3. The Poverty Line

The daily wages Rakku and her husband earn and the small portion of grain received for their harvesting labour, together with their son's earnings, are typical of the main sources of income for the landless. It means that if they work each day they can feed themselves and their family the following day. Wages, especially for women, provide barely enough for minimal nourishment, with nothing left over to save, let alone 'squander'. The country's definition of the "Poverty Line" points clearly to this economic reality for the labouring poor. A family is considered below the poverty line if by spending over eighty per cent of the total family income on the most inexpensive of foods (and cooking fuel) they are still unable to meet their minimum caloric requirements.⁹ Even government estimates admit that 48.8% of the population is now below this poverty line.¹⁰ And most recent studies suggest that the proportion of the population living below the poverty line is actually increasing.¹⁰

The Union Ministry of Labour itself has documented the increasing economic plight of the labouring poor. It reports that in 1974-75 the average daily money wage had decreased in real value by 12% from the previous decade. And further, that in the same period the total number of landless agricultural labourers had increased by 70% (from 28 to 47.5 million) while the number of "cultivators" (landowning families) decreased—a reflection of increasing numbers of small peasant families being forced to give up their land out of indebtedness and poverty.¹¹ In spite of deteriorating conditions for the poor, the per capita national product increased during the same period, indicating a further widening of the disparities in income between the rich and the poor.¹² Though subject to the usual and inherent limitations in data accuracy, such statistics reveal some basic facts and trends which are alarming.

What does it mean in concrete terms for a family to be living below the poverty line? What are the implications for the lives of its members? It means that whenever some work, however meagre, is available, they must work. To stop working, even for a day, immediately results

in even less food being available — or in increasing debt, which is usually a worse alternative than acute hunger. It further means that there is no extra money for such 'frills' as bus tickets to the health centre or town hospital. If such expenditures are incurred they are literally paid for with the food which would otherwise have partially filled their own and their children's stomachs.¹³ Obviously such an option is possible, but not easy — both in its unpleasantness and in the increasing risk that it creates. For each period of temporary starving decreases the family's ability to work and increases the risk of disease — the ever present malnutrition-infection cycle.

Once a family is in debt, either because of unemployment or sickness, or because it celebrated in the most modest way the wedding of a son or daughter, it becomes extremely difficult to pay back the money borrowed. It can only do this by decreasing the amount of food eaten, or tragically, as still happens, by parents allowing their children into bonded labour contracts with landowning families.¹⁴ Invariably the rural poor bear the burden of enormous interest rate payments to the local money-lenders, payments which over relatively short periods of time often total the entire sum originally borrowed. This burden is reflected in a study of one rural area of Tamil Nadu which found that lower caste and Harijan families routinely spend about 10% of their meagre income on interest payments.¹⁵ About two-thirds of rural households are now indebted and the percentage is gradually increasing.¹⁶ For the majority of rural families then, the struggle for daily-wage employment is continuous, and the balance between subsistence, indebtedness and hunger is extremely precarious. The implications of such economic insecurity for nutrition and health care are enormous.

Implications for Nutrition

The total income of Rakku's family is barely enough to keep the family fed. The majority of the rural poor subsist on coarse cereals which are the cheapest stomach-fillers available. In Rakku's area a coarse millet called Ragi is the main source of nourishment for the majority of families. Even lentils, which are said to be a common part of the traditional Indian diet, and which are repeatedly termed the "poor man's protein source" by nutrition experts, are a luxury which most of the labouring poor cannot afford except for special occasions such as marriages and perhaps important religious festivals. The traditional Western and affluent Indian protein foods such as milk, eggs or meat play no part in the regular diet of the poor. Indeed, even rice is usually a luxury food saved for special celebrations.¹⁷

So the diet of the rural poor in this part of India is basically a coarse cereal boiled into a porridge and flavoured at most with bits of crushed chilis or a little onion. Even the traditional Indian spices are a luxury. The question of *quality* of nutrition, however, pales into insignificance compared to the fact that for varying parts of the year there is not enough of even this simple staple cereal available to labouring families. Banerji's rural study for example showed that over 36% of families in the villages studied did not get "two square meals a day to satisfy thier hunger" for at least three to six months of each year. "Yet it is precisely those who subsist on such an unbalanced, monotonous and inadequate diet who at the same time perform most of the strenuous physical labour in society. The costs of such a contradiction are stark, in terms of malnutrition and higher death rates both for labouring adults and for their children, as we will consider in chapter two.

Implications for Health

Once we understand that about two-thirds of Indian families spend over eighty percent of their income on food, and that more than half of these families still fail to meet basic caloric needs, we can begin to appreciate the economic dilemma the majority face in seeking health care. How likely is it that such families will have money in hand for bus fare to take a sick child to a hospital, let alone to the rural health centre for preventive care? Even more basic than this, how can a woman absent herself from her field work to care for a sick child when the loss of her daily wage immediately means increasing undernutrition for both herself and her child? How realistic is it even to expect a village woman to stay back from the field work to receive any portion of the health services offered by the health centre paramedics when they randomly (from her point of view) visit her village? For the labouring families the dilemma posed by such poverty is painfully expressed by a young mother from Rakku's village: "When only the field work is important, how can the child be healthy?!"

Such questions must lead to a re-consideration of the relevance of the existing health system for the common labouring family. But first let us return to Rakku's village to consider more closely how her poverty has affected the health of her children.

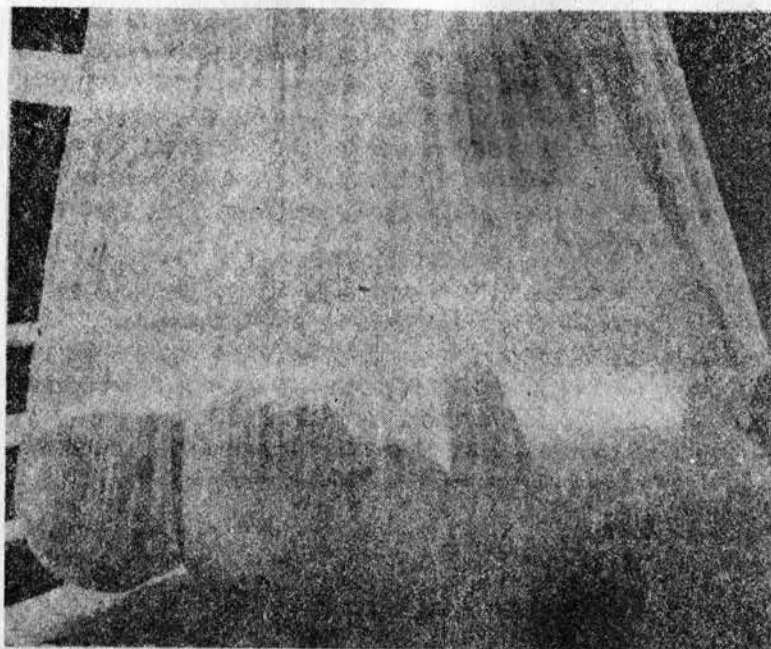
Rakku's third child was born three years after her daughter, Ponnu. The baby died of tetanus one week after birth, a common cause of death in newborns. The tetanus infection develops from the umbilical cord, tetanus spores abounding in the rural homes. This infection is, however, completely preventable with two tetanus toxoid injections during pregnancy.

The Indian government has recognized the importance of tetanus in newborn mortality by including antenatal immunization as one of the major activities of female health workers. However, it is also true that health workers usually reach only a small proportion of villages within the Health Centre's jurisdiction, primarily those on direct bus routes. And even in these villages, many women remain outside the programme because of their field work or other labour preoccupations.

To compound the problem, the inclusion of Family Planning promotion among the duties of health workers, and the much greater pressure to achieve targets in this field, mean that the villagers tend to develop a deep suspicion of government health workers. The number of women reached by the immunization programme thus becomes even smaller. And so it is that almost half a million young infants continue to succumb every year to a disease that, technically speaking, is extremely easy and inexpensive to prevent.

Thus poverty and the economic structures of rural life which determine the working conditions for women, often put even the village-level activities of the government health system beyond the reach of the rural poor. But the conditions and hours of work for labouring women are in themselves directly responsible for the high levels of illness and malnutrition in children. One of the major factors leading to childhood malnutrition in this rural area in India is the absence of the mother from the home during the day.¹⁹ As a result, young children are fed infrequently. This inadequate feeding includes breastfeeding as well as supplemental feeding, for the working mother usually returns to the daily field work within a month or so of giving birth, and is henceforth separated from her infant almost the entire day. Indeed, if it happens to be harvest season, labouring women feel compelled to return to the fields within a week or so of childbirth. Sometimes it is possible for a mother to take her very young infant to the fields if there is a tree closeby where she can tie a small hammock for the child. But this is the exception. More often an elder child may be able to bring a young infant to its mother in the fields for nursing, but even this is too infrequent for adequate breastfeeding, especially if the fields are a kilometre or more away.

Consequently, instead of three or four meals a day which the six month old child requires in addition to breastmilk, he is fed only once or twice, as with the rest of the family — in the evening, and perhaps again in the morning. Many young children have only a slightly older sibling looking after them during the day and this generally makes sufficient feeding or basic care impossible. Until Rakku's mother-in-



Day care for children of the poor

law died two years before, the old woman had been looking after the young children, at least for the last year or so of her life when she was too weak to do any of the field work. It is often assumed that there will be an older woman, a grandmother, in village families who can look after the young children when their mothers are away working. In fact, however, it is often only the landowning families which are truly "extended families" with a number of relatives and grandparents under one roof. Such an arrangement is possible for the larger landowning families because the income base is large enough for all to live from it and therefore together. This is however not the case for the poor and especially for the landless.²⁰ The joint family system breaks down in the far more practical pursuit of work. Adult family members go where there are landowners who will hire them, or where other seasonal or sporadic work is available. If an older relative/grandparent lives with a nuclear family, he or she will most likely be an active working member until too frail to collect even twigs for firewood, and therefore also too weak to care adequately for young children left at home.

The implications for the nutrition and general care of children of labouring women are obvious. But the problem is not simply that

women are working, but rather, *the severely exploitative conditions under which they labour*. If rural women were organized to achieve higher wages, job security and day care facilities for their young children, this would enable them to feed their children adequately, and to care for them when ill, without bringing economic ruin to the household. Such alternative solutions are considered in the final chapters of this book.

4. Women and Ill-health

Within the hand-to-mouth existence of all the labouring poor, it is also abundantly clear that women bear an additional burden. Traditional cultural beliefs which prescribe a lower status and minimal rights for women throughout society, predictably lead to their even greater ill-health burden. This belief system affects labouring women at two levels; that is, *between* classes — their greater exploitation by landowners — and *within* the labouring class itself.

For example, such a belief system justifies markedly lower wages paid by landowners to women labourers, though in most cases women are as productive as men in the work they do. The economic plight and dependency of labouring women also often leads to their sexual exploitation by landowners.

In addition, though the more overt forms of women's lower status, such as dowry, bride-burning and oppressive seclusion, are much less evident within the labouring classes themselves (as compared to the middle and upper classes), it is also true that even within labouring families, women continue to bear a *double, even triple, burden* — of childbearing, child care and household labour, in addition to labour outside the home. A recent study of nutrition and energy expenditure²¹ reflects this triple burden, finding that women account for 53% of daily energy expenditure in rural households, compared to 31% for men and 16% for children. The same Karnataka study found that women expend about 700 calories, or one third of their energy expenditure, on the domestic tasks of cooking, and firewood and water fetching. And these figures do not include the enormous and *continuous* nutritional drain of breastfeeding and/or pregnancy!

Such additional physical burdens play a major role in continuing ill-health and higher mortality in women and children. Not surprisingly, average life expectancy for women is lower than for men. India is thus one of the few countries in the world where this unnatural adverse sex ratio exists.²² Another important reason for this reversal is the greater female mortality in young children, a reflection of the greater economic value of male offspring.



One aspect of women's "triple burden"

In spite of the importance of such cultural factors, this study focuses on the over-all economic determinants of ill-health. This is so in part due to constraints of information, and of space (analysis of ill-health in women deserves an entire study onto itself); and in part, out of the belief that the *primary* cause of ill-health in labouring women is, as can be seen in Rakku's Story, the general poverty of their families — poverty which, as we will explore further on in the analysis, is prescribed by exploitative class relations in society as a whole. *Clearly however, the culturally-determined lower status and oppression of women compounds their burden of ill-health and therefore is an issue which demands to be specifically and clearly addressed in any social change effort.*²³

This chapter has briefly described the economic reality of Rakku's life and the lives of the labouring rural majority, which makes basic health care inaccessible and of minimal priority in the far more immediate struggle for daily food. Unfortunately, the profound and central importance of adequate food for health is so obvious that this simple reality has often been ignored in the rush for technical answers to the ill-health problem. A recent analysis of health in Bangladesh offers a clear and long-overdue reminder that health "remains

determined by access to food at a minimal if not decent level of nutrition." The author concludes that "the right to food is the basic requirement for the right to health. Improvement of people's health cannot take place without recognition and enforcement of this political right."²⁴

NOTES

1. While about half the population live below the poverty line, among the Scheduled castes and tribes, it is over 80%. See J. Kananaikal, "Hope out of Suffering", *IE*, 7 Jan. 1982.
2. According to some statistics, 57% of the country's rural population belong to families which own no land or so little — less than 2.5 acres — that they are unable to provide for their own food requirements. The livelihood of these families depends mainly on seasonal labour on the land of the larger landowners. 60% of agricultural land continues to be owned by 12% of rural families. Nationally, over 26% of rural families own no land at all, while the bottom 44% of rural households own only 1.6% of cultivated land. See for example, D. Barreto, *The Indian Situation*, Centre for Social Action, Bangalore, 1977, p. 40.
3. For a detailed study of agricultural production and labour, see J. Mencher, *Agriculture and Social Structure in Tamil Nadu*, Allied Publishers, New Delhi, 1978.
4. K.C. Alexander points out that in 1961, 45% of the population in Tamil Nadu were working, commenting that "this large proportion of workers... seems to be due to the large number of children, women and elderly persons working because of an inadequate source of income from adult males on whom they depend", in *Peasant Organizations in South India*, Indian Social Institute, New Delhi, 1981, p. 31.
5. For a detailed and up-to-date report on child labour in the matchstick cottage industries of Tamil Nadu, see S. Kothari, "There's Blood on Those Matchsticks: Child Labour in Sivakasi", *EPW*, 1983, pp. 1191-1202. The employing of children in dangerous factories is not a phenomenon limited to Tamil Nadu. D. Banerji, for example, describes a Karnataka match factory in which many girls of less than 12 years work for Rs. 5 or 6 per week (in *Poverty, Class and Health Culture in India*, Vol. I, Prachi Prakashan, New Delhi, 1982, p. 47.) Likewise, in reporting a fire in a fireworks factory in Gwalior in Dec. 1981, in which 6 of 11 deaths were of women and children, *The Times of India* noted that 150 of the 250 workers were children less than 16 years of age, and added: "No labour laws were implemented in the factory as all the workers... were considered as casual labourers" (in "11 Killed in Fire at Gwalior", Dec. 4, 1981, p. 3.)
6. Kulshreshtha, J.C., *Child Labour in India*, Anish Publishing House, New Delhi, 1978, p. 4.
7. *Health for All: An Alternative Strategy*, ICSSR/ICMR, 1981, p. 8.
8. For the on-going debate on measurement of and trends in poverty in the country, see Dandekar and Rath's initial study "Poverty in India", *EPW*, 1971, pp. 25-48 & 106-146; as well as more recent articles, such as P.V. Sukhatme, "Assessment of Adequacy of Diets at Different Income Levels", *EPW*, 1978, p. 1373; V.M. Dandekar, "On Measurement of Poverty", *EPW*, 1981, p. 1241; P.V. Sukhatme,

"On Measurement of Poverty", EPW, 1981, p. 1318; H.K. Paranjape, "How Poor Are We?", EPW, 1981, p. 1470; D. Banerji, "Measurement of Poverty and Under-nutrition", EPW, 1981, p. 1579; V.M. Dandekar, "On Measurement of Under-nutrition", EPW, 1982, p. 203; and P.V. Sukhatme, "Measurement of Under-nutrition", EPW, 1982, p. 2000. A critique of Sukhatme's position is given in chapter 9 of this book. Banerji's pragmatic measurement of poverty involves grouping the population according to "whether a family gets enough food to have two full meals (whatever the composition) throughout the year... as a broad yardstick for demarcating the poor from the rest. Those who did not get enough to eat for more than 6 months in a year were 'abjectly poor'" (in *Poverty, class and Health Culture*, op. cit., pp. 54-55).

9. *Sixth Five Year Plan*, op. cit., p. 18.

10. One estimate is that 30% of the population were living below the poverty line in the early 1960s. For details, see Dandekar and Rath (1971), op. cit., pp. 28-9; Barreto, op. cit., pp. 11-17; and also A.N. Agarwal, *Indian Economy*, Vikas Publishing House, 1980, p. 127. The significance of living 'below poverty line' is clearly expressed by Agarwal: "To identify the poor in India, one has to use the criterion of minimum requirement of necessities. Of course, this will not meet the test of reasonable existence, much less of comfortable life, but it should provide what is essential for physical existence. It is in the light of these that almost all estimates of poverty in India are related to expenditure, mostly on food... The poor can thus be described as those who are not able to meet the minimum requirements of physical life... Those people are poor who do not possess adequate purchasing power to buy as much food as can generate energy in their bodies equivalent to 2,250 calories per capita per day" (Ibid, p. 126).

11. In "Getting Poorer", EPW, 1978, pp. 1726-7.

12. Mitra, Ashok: *India's Population*, A Family Planning Foundation/ICSSR Book, 1978, p. 711. Mitra observes that the "per capita increase in net national product from Rs.306 to 366 from 1960-61 to 1975-76 (at 1960 prices) has been offset by the widening disparities in income between the rich and poor".

13. In her detailed village health study, C.M.E. Matthews found that 21% of village families were spending between 90% and 100% of their total income on food, and another 25%, 80 to 90% (in *Health and Culture in a South Indian Village*, Sterling Publ., 1979, p. 113).

14. A 1978 national survey of ten debt-bondage affected states estimated that there were a total of 2.6 lakh bonded labourers constituting 5.7% of all agricultural labourers, in these states; that 87% of these were from Scheduled castes/tribes; and that 25% were less than 20 years of age (cf. Sharma, Marla, *Bonded Labour in India*, Biblia Impex Priv., New Delhi, 1981). In the mid-1960's, 6% of debts were hereditary, that is, handed down from one generation to the next; while in the 1970's, such debts still comprised more than 5% of the total (cf. *Rural Labour Enquiry*, 1974-75).

15. Matthews, op. cit., p.53.

16. A recent survey conducted by the Rural Labour Enquiry in 1974-75 reveals that "the proportion of farm labour households which were indebted increased from 60.6% in 1964-65 to 66.4% in 1974-75... It is noteworthy that the increase... was the heaviest in the two agriculturally most prosperous states of Haryana (80%) and the Punjab (75%)". Furthermore, the study reveals that (1) "money lenders remained the single major source of borrowing for the labour households... The share of institutional agencies... was negligible"; and that (2) "loans taken for

household consumption continue to be the single dominant factor responsible for debts" (in EPW, 1979, pp. 893-4).

17. If labourers are paid in kind for their rice harvesting, this rice may last them 1 to 2 months of the year. For the remaining months cheaper coarse cereals, such as ragi, are purchased. G. Djurfeldt and S. Lindberg describe a similar diet for labouring families in a northern area of Tamil Nadu (in *Pills Against Poverty*, Oxford & IBH Publishing Co., 1976, p. 71). It has been estimated that a balanced diet containing no animal foods whatsoever — that is, cereals, greens pulses & vegetables — for a child under five years of age, cost in 1980 a minimum of Rs.1.65 daily — clearly an amount which is not within the reach of daily wage labouring families. (Such a diet represents 1474 calories, 42 grams protein, and 5000 I.U. B-carotene). Source: A *Short Report on the Working of the Nutrition Rehabilitation Centre at the Gov't Rajaji Hospital, Madurai*, 1981.

18. op. cit., Table 10, p.238; emphasis added.

19. According to Leela Gulati, the proportion of women in the workforce varies greatly among states, from 5 - 10% in the Punjab and West Bengal to almost 50% in Himachal Pradesh, M.P. and A.P. (in "Occupational Distribution of Working Women: An Inter-State Comparison", EPW, 1975, pp. 1692-1704). Tamil Nadu, at 31%, is in an intermediate position. (These figures represent full-time and "secondary activity" work participation.) While 21% of Indian male workers are agricultural labourers, 46% of female workers are engaged in daily wage agriculture labour.

20. Describing a village area in northern Tamil Nadu, Djurfeldt and Lindberg also report that "only a small minority (9%) are joint families consisting of two or more related nuclear families" (op. cit., p. 38).

21. S. Batliwala, "Rural Energy Scarcity and Nutrition: A New Perspective", EPW, 1982, p. 329

22. The Union Health Minister reports that between 1976 and 1981 life expectancy for men was 52.6 years while for women it was 51.6 years (in *IE*, Dec. 13, 1981, p. 7). Furthermore, throughout most of this century this adverse population sex-ratio has been worsening. In 1901, the ratio was 972 women per 1000 men; in 1971, it was down to 930. The provisional estimates for 1981 speak of 935; in spite of a slight improvement, the gap remains wide. On this see *Status of Women in India*, ICSSR, 1975, and *India Today*, April 1-15, 1981, pp. 104-5.

23. For specific studies of women's issues, see for example, Gail Omvedt's *We Will Smash This Prison!*, Orient Longman, 1979, which includes a useful bibliography on women in India; as well as recent articles such as: K. Saradamoni, "Women's Status in Changing Agrarian Relations: A Kerala Experience", EPW, 1982, p. 155; G. Omvedt, "Women and Rural Revolt in India", *Social Scientist*, Aug. 1977, pp. 3-18, and Sept 1977, pp. 21-41; L. Gulati, op. cit.; and Journals such as *The voice of the Working Woman*, and *Manushi*.

24. Fleri, Louis-Francois, *Issues in Health and Nutrition in Rural Bangladesh*, United Nations Asian & Pacific Development Inst., 1980, p. 1-2.

CHAPTER II

Ill-health: Myths and Realities

The previous description of the economic barriers which exist for a village labouring family reveals some of the reasons why modern health care is generally beyond the reach of the rural majority. It also reveals how poverty (and as a consequence, malnutrition) is the major source of ill-health. In this chapter we will investigate the specific causes of preventable deaths and illness in the country, and where exactly the burden of ill-health falls most heavily. In spite of a dearth of detailed studies and the difficulties in generalizing to the country as a whole, certain trends are clear.

1. Where the Burden of Ill-health Falls

The significance of mortality data is clear if we divide the population into three main age groups:

- i. young children — less than five years of age,
- ii. older children and adults up to 65 years of age,
- iii. adults over the age of 65 years.

Various rural health studies have shown that deaths in the first group, that is in young children, represent between forty and fifty-five per cent of all mortality in the country each year.¹ (By comparison, deaths in children under five years represented 2.7% of all deaths in Canada in 1980).² It is even more significant when one considers that childhood deaths represent almost two-thirds of all *premature* deaths each year — that is, deaths occurring before the age of sixty-five years. It hardly needs to be argued that such deaths are the true priority in terms of health planning.

What do these figures mean in terms of the number of children dying? In fact, it means that approximately *one quarter of all children in India die before they reach their fifth birthday**. Considering that twenty-two million children are born each year, this means a minimum of *five million deaths* in young children every year.

* An explanation of this general estimate is given in Appendix I.

2. Causes of Mortality

The vast majority of these early childhood deaths — perhaps 4½ million — are due to easily prevented or treatable diseases. Diarrhea, tetanus of the newborn, pneumonia, measles, typhoid, and TB lead the list — all infectious diseases for which immunization or simple treatment is possible. Prematurity and birth injuries are the major non-infectious causes of death in young children. A more detailed summary of causes of childhood mortality is included in Appendix II, but it is useful to give here a certain idea of the actual numbers of children involved in these statistics: diarrheal dehydration probably accounts for about one million childhood deaths each year; and newborn tetanus and measles respectively, almost one half and one quarter of a million.

The Role of Malnutrition

In most studies, malnutrition deaths are not classified separately, except for the most severe cases, termed ‘*marasmic-kwashiorkor*’.³ However, it is widely recognized that malnutrition underlies the great majority of these five million childhood deaths — the undernourished child succumbing much more easily to the ‘common’ infections such as diarrhea, measles and TB.

While the capacity of a child to recover from almost any infection is less when undernourished, this vulnerability is even more apparent for measles. Measles is very often fatal for the severely malnourished child, whereas for most well-nourished children it means simply a few days of fever.⁴ Many village women in southern Tamil Nadu are aware of the two different forms of measles infection, and give the special name, ‘*chechchilepenn*’, to severe measles in contrast to the general term, ‘*manilvari*’. They are also surprisingly aware of which children are likely to develop the severe form — namely, those living in the tiny huts, the children of the poor.

But malnutrition plays an important role even in some newborn deaths, particularly those due to ‘prematurity’. The frequency of underweight newborns is closely related to the undernourished state of labouring women who, because of inadequate diet and the demands of their daily labour, give birth to infants smaller and therefore often weaker than infants of non-poor mothers.⁵ While traditional family beliefs prescribe special care to women in advanced pregnancy, poor women often have no choice but to work until the very day of childbirth.⁶ In southern Tamil Nadu, children of the poor are not uncommonly given such names as Kattu-rani or Kattu-raja, meaning queen or king of the fields because they were actually born in the agricultural fields.

The extent of malnutrition in young children has been estimated in various studies. A well-known study carried out by the National Institute of Nutrition in the early 1970s found that 18% of children were severely malnourished, and another 65% moderately malnourished.⁷ Not surprisingly, various food intake studies reveal grossly inadequate food consumption for large proportions of young children. For example, a Punjab study found that between 65% and 79% of young children (between 6 and 24 months of age), and 61% of breastfeeding mothers, were receiving less than 75% of the food calories as recommended by the Indian Council of Medical Research.⁸ Though the "recommended food intake" is thought to allow for a safety margin above the absolute minimum requirement for health, it is reasonable to assume that food intake below 75% of this quantity represents significant under-nutrition. It is even more significant that a comparison of the nutrition status of children observed in 1955 and 1978 "shows very little improvement. If anything, the figures for 1978 appear to be somewhat worse".⁹

Food intake is directly related to family income. A 1978 working paper for example showed that only 5% of Indian children reach the average weight of children from affluent Indian families.¹⁰ Two further studies also document the relationship between poverty and malnutrition. The first reveals a progressive and dramatic deterioration in food consumption with decreasing landownership in all of the nine major states studied.¹¹ And the second indicates a mirror relationship between decreasing income/expenditure and decreasing percentage of rural families with adequate food intake.¹²

What does undernutrition imply for the children of the poor? The high proportion of children in government (public) hospitals who are severely malnourished speaks clearly of the relationship between malnutrition and disease. There are, however, few rigorous studies of mortality rates and malnutrition — in part due to the difficulties of obtaining such data. (In identifying severe malnutrition, it is difficult for the health/research worker not to respond to the immediate medical and nutritional needs of these children thus distorting study "results".) Nevertheless, research in several Third World countries has shown markedly higher illness and death rates in children who are under-nourished. For example, a recent Bangladesh study has shown that young children in moderate to severe state of malnutrition had a twenty times greater risk of dying within the following month than did adequately nourished children from the same village.¹³ Such findings only serve to confirm the experiences of rural and slum health workers

who witness the intimate relationship between poverty, malnutrition, disease and high death rates.

3. Which Young Children?

We have been considering childhood mortality rates for the country as a whole, finding that roughly one quarter of children die in early childhood. But because these data represent a *composite* picture, the figures tend to obscure the very great differences in death rates between social groups.

It has been long recognized that mortality rates are considerably higher in rural India than in the urban areas. A recent Government of India study confirmed again these differences: rural infant mortality was found to be twice as high as the urban rate (136 as compared to 70).¹⁴ It is also clear that particular socio-economic groups have very different rates of mortality — which is indeed predictable from the nutrition data considered earlier. Unfortunately, most studies have not rigorously looked at mortality by *socio-economic* group. If at all, they have done so only indirectly. The few direct studies which exist are mostly limited to small population bases and are admittedly of varying degrees of scientific value. While it is impossible to make firm general statements from these studies, they suggest an important trend.

Several studies in the past decade have *indirectly* provided child mortality data in relation to socio-economic groups. The Government study just mentioned looked at infant mortality in relation to a number of factors — and the one factor which more clearly reflects the "level of living" and family income was household lighting. Rural homes with electric lighting showed an infant mortality rate of 87, while those with oil lamp lighting had one of 163.¹⁵ Perhaps the most significant finding of this study is that this *ECONOMIC* factor was found to predict infant mortality much more clearly than such *COMMUNITY* factors as drinking water source, or availability of medical facilities.*

1978 Rural Infant Mortality Rates (per 1000 live births)		
	Variable	Infant Mortality
A. Drinking Water Source	— Tap	103
	— Well	137
	— Pond/Tank/River	105
B. Medical Facilities	— With (less than 5 km. distant)	102
	— Without (more than 5 km.)	136
C. Lighting Source	— Electric	87
	— Oil Lamp	163

Source: Survey on Infant and Child Mortality, Office of the Registrar General, Ministry of Home Affairs, New Delhi, 1979, pp. 36-7.

A detailed Tamil Nadu study has considered child mortality from the viewpoint of caste.¹⁶ The death rate was found to be 159 for the traditional cultivator caste, Gounders, compared to 266 for Harijan families. Yet this study too, failed to look directly at economic status. In fact, over one third of the Gounder families are landless labourers, and one fifth live on a yearly income of less than Rs.1000. If one assumes that these families probably have child mortality rates rather similar to the Harijan section, it can be estimated that the larger landowning Gounder families have a child mortality of approximately 100. This, in contrast to 266 for the lower socio-economic labouring families.

Banerji has uncovered, in a more direct manner, a similar pattern between mortality and socio-economic group. His study of nineteen villages in eight different states showed that, in spite of a significantly lower number of births in "poor landless labouring" and Harijan families, the proportion of families with four deaths or more was 10% for landless labourers and 18% for Harijans, as compared to 5% or less for landowning families.¹⁷ Banerji further observes that "the villages which report a high percentage of those who are unable to get two square meals, also have a high proportion of landless labourers and a higher proportion of deaths among children".¹⁸

Smaller studies reveal equally large differences in child mortality between socio-economic groups. For example, a Delhi survey in the mid-1960's found a child mortality of 13.6% in the poorest families (Class IV) compared to 2.1% and 3.3% in classes I and II.¹⁹ A 1967-68 Lucknow study showed an infant mortality rate seven and a half times greater in families with a monthly income of less than Rs.75 than in families with monthly incomes of over Rs. 300.²⁰ Finally, it is revealing to look at child mortality rates in special groups of the poor. A recent study of mortality in the young children of women construction workers in Delhi found a 40% mortality rate — that is, 400 deaths for every 1000 children live born to these women.²¹

What can we say then, about ill-health and social structure? Such studies tell us that the burden of ill-health falls most heavily on a special group of people in society — on the poor, and perhaps most visibly on the young children of the poor. This is not to imply that all preventable childhood deaths occur exclusively in labouring, poor families. There is no question that a significant number of child deaths occur even in non-labouring middle class rural families — which is perhaps predictable from the urban-rural maldistribution of health workers and resources in the country. But the proportion of

deaths is clearly related to income and therefore to poverty and hunger, leading to dramatically higher rates of "wastage of children" in the landless and labouring section of the people.

And further, though specific data are not available, it is likely that the gap in child mortality rates between the upper and lowest socio-economic classes is actually widening. For the second significant point is that *the rural areas, which account for 80% of the country's children, have seen no apparent improvement in mortality rates over the past decade.* The infant mortality rate was the same 136 in 1970 as in 1978, while urban rates continue to decrease.²² The rural rates remain stationary in spite of specific achievements in the past decade, including the eradication of Smallpox, slight declines in birth rates, as well as some extension of drinking water supplies and broader extension of the 'Green Revolution' activities.

While health care is becoming increasingly available to the urban elite and middle classes, the continuing (indeed, deepening) poverty of the rural poor is reflected in the observed lack of improvement in infant and child mortality rates.²³ As disparities in income increase in society, so, predictably, do the disparities in health status.

The fact that almost two-thirds of the country's excess, easily preventable mortality occurs in young children highlights where the health system's priorities must lie. But it is equally true that a health system alone cannot solve such enormous mortality problems when the issues lie largely within the realm of poverty, malnutrition and the unjust exploitation of the labour of the poor, including that of women and children. What the statistical data accurately reflect is that the burden of this exploitation falls most heavily on the young children of the poor.

4. Insufficient Explanations

In seeking to understand the reasons for the continuing

* This analysis focuses particularly on child mortality because such deaths represent so large a proportion of excess, preventable mortality in the country. This is not to suggest that preventable mortality in adults and older children is not also high. And likewise, in considering premature adult mortality, a similar poverty-related profile is clear. For example, TB is probably the number one cause of premature deaths in adults,²⁴ and is a disease clearly associated with poverty. (While exposure to TB is common throughout the population, deaths due to the disease are heavily concentrated in the lower socio-economic groups.) A conservative estimate is that 5 lakh deaths each year are due to tuberculosis.²⁵

underdevelopment of health in India it is worthwhile to briefly examine a few of the commonly cited explanations for childhood malnutrition and mortality, explanations popular among international development agencies, and in government and medical circles within the country.

i. Ignorance about Nutrition

A very popular belief among health advisors is that children are malnourished *primarily*, or at least to a great extent, because the poor are ignorant about proper nutrition. The conclusion which springs naturally from this assumption is that the solution to malnutrition can be 'grassroots' nutrition education.

Delayed and inadequate supplementary feeding (that is, solid food in addition to breastmilk) is often said to be the main cause of malnutrition in children aged 6 months to two years. And it is certainly true that many village infants are not given supplementary food until 9 or 12 months of age. Even then, such feeding is often too infrequent, perhaps only once a day instead of the ideal of three or four times. Thus, nutrition experts exhort rural mothers to feed their young children more frequently and earlier. Such advisors, however, overlook — or indeed are entirely unaware of, the difficulties and legitimate fears of the village mothers in heeding such advice.

Lack of time and money are devastating constraints, especially for the labouring mother. Unable to afford fuel to cook more than once a day, she cannot make special preparations for her infant. Still more important, women in this part of India are rarely present in the home for the luxury of feeding their infants throughout the day — a task which requires considerable time, patience, and coaxing, as any mother in any country experiences when she starts her infants onto solid foods. For the labouring poor there is often no adult or even sufficiently mature elder sibling at home to substitute for the working mother.

But in addition to direct poverty constraints, village mothers are also acutely aware of the risks associated with starting their infants on solid foods. Fortunate is the labouring woman who has not lost a child to diarrheal dehydration. The association between supplementary feeding and diarrhea is vividly real and threatening for them — just as it was in Europe and North America in the early part of this century when Western paediatric texts advised exclusive breastfeeding until nine or twelve months of age.²⁵ Theoretical awareness of intravenous rehydration methods to save a child with severe

diarrhea can hardly offset their general fear of diarrhea, because access to such care is economically not feasible for them — as it is for the well-to-do village families. This is not to suggest that many diarrheal deaths cannot be prevented by simple oral rehydration methods with adequate (that is, accessible) hospital back-up, as the Jamkhed and other village health programmes have shown. The point is that such prevention methods and close hospital back-up are not a reality for the rest of the country, which makes the fears and constraints of labouring mothers very real and legitimate.

Furthermore, while it is true that the poor are unaware of most scientific nutrition information, this is equally true for the more affluent village families whose children are *not* malnourished.

But the nutrition education argument is inadequate for another reason. Malnourished children in India do not die from lack of one particular nutrient, but rather from insufficient food generally. Though consisting mainly of simple porridges of coarse cereals, children's diets are usually adequate in protein content. Rather, they are grossly deficient in overall calories, that is in *quantity* of food. If the children of the poor were fed sufficient quantities of virtually any local Indian food, their protein intake would also be sufficient.²⁶ Malnutrition is most severe and takes its highest toll in infants and young children in the age group of six months to two or three years. And the primary reason is that their mothers are simply unable to prepare food and to feed their children an adequate number of times during the day. Thus, while nutrition education might improve specific deficiencies such as Vitamin A deficiency, it in no way can substitute for adequate child care and feeding.²⁷ When labouring women in Rakku's village were asked why some children become malnourished, their answer was touched with a hint of exasperation for to them it was so obvious. "No money and no time!" they replied. Indeed, considering their level of poverty, it is remarkable that labouring families survive nutritionally as well as they do! Matthews comments: "In fact, the diet used is probably not so far from the *best* that could be done with the money available".²⁸

This section is hardly meant to suggest that nutrition information should not be made available to the masses. On the contrary, access to such information, along with health and all other basic scientific information, is their fundamental right. Rather, this critique is offered simply to highlight the utter inadequacy of nutrition education strategies as a *solution* to the problem of malnutrition and ill-health.

ii. Reluctance to Accept Modern Medicine

The second myth which the preceding description of village economics exposes is the assumption that the village poor do not use the modern health system out of ignorance and stubbornly-held beliefs in traditional health methods. On the contrary, the poor in this part of southern India fail to make use of the health system primarily for economic reasons. They simply cannot afford to do so. The cost of seeking out modern health care, in terms of transportation, but more importantly in terms of lost labour and wage, is insurmountable. In his detailed study of rural health behavior Banerji, likewise, concluded that "the surprising finding was that the response (of villagers) to the major medical care problems was very much in favour of the Western allopathic system of medicine, irrespective of social, occupational, and regional considerations... Availability of such services and the capacity of patients to meet its expenses were the two major constraining factors".²⁹

That villagers continue to use and have faith in various forms of traditional and folk medicine is undeniable. Yet it is questionable how much of this is inappropriate or "irrational". The reason for choosing folk medicine is in many cases pragmatic balance between economic costs and varying degrees of effectiveness of the traditional versus modern systems. Djurfeldt and Lindberg document how the low standards and the limited nature of available modern health services often make the choice of local healers as effective and rational as that of allopathic care.³⁰ At the same time, however, if modern care is within reach, it is extensively, and often preferentially, used.

This does not mean that patently useless and even harmful folk practices do not persist in many rural areas. But this deplorable fact may well be more a reflection of the overall inaccessibility of alternatives, than due to stubbornness on the part of the rural poor — an indictment not so much of the villager, but of the rural health system, and the fact that most allopathic doctors are in private practice. Likewise, Djurfeldt and Lindberg conclude: "One could perhaps say the... most fundamental reason for the apparent relative efficiency of indigenous medicine is the inefficiency of the allopathic one... Allopathic medicine (in the form in which it has so far been supplied) is unable to solve the health problems of Thaiyur (the village studied)... The impotency of allopathic medicine allows the indigenous systems to survive."³¹

iii. Too Many Children

A third myth dominant in Indian health analysis is that the poor produce children in an uncontrolled and irrational way, and that their larger number of children is a fundamental cause of malnutrition and ill-health. Because of the complexity of this issue and the continuing dominance of Western demographic theory in India, the whole question of population growth deserves more detailed attention.

The past several decades have seen the development of an enormous international thrust for global population control. The methods of analysis, the very definition of the "population problem", and much of the funding for Family Planning activities, have come almost solely from the industrialized countries of the West, particularly from the U.S. The main target for such population control activities has been the non-socialist countries of the Third World. Recent critiques of international population control "aid" have exposed the analytical inadequacies, confusion, and most importantly, the ulterior motives underlying much of these efforts.³²

The superficial nature of most Western population theory is revealed in its overwhelming emphasis on describing *what* is happening in terms of growth rates, to the almost total exclusion of *why* it is happening. This panic-creating 'numbers approach' has reduced the understanding of population growth to a series of abstract statistics which obscure what exactly is happening *at the family level*.³³ In the Indian context then, let us first look at what the demographic factors are.

In the mid-1950s, India became one of the first countries in the world to adopt a national Family Planning programme. By the late 1960s the Central government was channelling massive amounts into this programme, funding which in the Fourth Plan exceeded the entire allocation for all health programmes.³⁴ In spite of this spending, the birth rate remains high at 36.6 births per 1000 population per year.³⁵ Though considerably lower than in many Third World countries, the present growth rate means that the population is doubling approximately every 35 years. At the time of Independence in 1947 the total population was 350 million; it is now more than 700 million.

The assumptions which have dominated official thinking about population growth include the following:

— Indian villagers are having children in an uncontrolled way:

- This is due to ignorance and lack of planning methods;
- This excessive childbearing is a burden not only to the nation, but to the individual village families themselves.

A number of recent studies³⁶ have shown that all of these assumptions are incorrect, except the counter-productiveness of continuing high growth rates to the country as a whole. Let us therefore look at each of these assumptions more closely.

a. Are village families unplanned?

Studies in various parts of the country over the past several decades reveal the following basic demographic data. Though there are regional differences,³⁷ these figures represent an averaging of data regarding family size, birth intervals (spacing of children) and duration of childbearing for Indian women.

Family Size: The average number of births in rural families appears to be between six and seven, while the average number of *surviving children* (that is, completed family size) is 4.2 children.³⁸ Thus, the average number of children born to rural families is considerably below the *potential* reproductive capacity of couples. Furthermore, some recent studies have found that the poorest rural classes have significantly fewer total births per family than the major landowning families.³⁹ Not surprisingly, the actual number of *surviving children* is significantly lower in the lower socio-economic classes in most studies than for the higher classes.

Birth Interval: The average interval between births is approximately three years in the rural areas (though somewhat less than this in urban areas recently), an interval which is considerably longer than what would be expected biologically. In other words, couples appear to make specific efforts to space the births of their children.

Age at Last Pregnancy: The average age at last pregnancy for rural women is approximately 35 years, an age which is also much lower than the biological reproductive potential.

All of these facts indicate that rural families not only attempt to plan their families, but have been doing so to a significant degree, and without modern technology or motivation; for much of this data was taken in areas before the introduction of intensive Family Planning activities.

b. Ignorance of Family Planning Methods?

Various studies have looked at some of the methods used by rural

families to space and limit their children. Abstinence and prolonged breastfeeding appear to be the prime ways couples limit family size. Village-level abortion, particularly in older women, is also a major factor. It is estimated that up to four million births are prevented by village abortions every year,⁴⁰ compared to a total estimated 1.4 million "avoided births" in 1968-69 through the entire official Family Planning programme.⁴¹

The motivation for these traditional methods of family planning is also clear. Parents recognize that a long interval between births is essential for the health and nutrition of their children. Hence the traditional period of abstinence after childbirth. In southern Tamil Nadu the local term for a "kwashiorkor" malnourished child is "sevalie" which means "the disease of the young child who grows lean for want of mother's milk" — that is, the child who is prematurely taken off breastmilk because of the birth of a younger sibling. A village woman feels considerable shame if she conceives before her previous child is well beyond infancy. As well, a woman in her late thirties who normally has post-pubertal or married daughters, feels shame if she conceives again. Thus, older women often resort to local village abortions.

c. Do "too many children" cause high child mortality?

It is often assumed that high child mortality rates occur because families have too many children — too many mouths to be filled by too small a pot! Yet a number of studies show that the highest death rates are in first- and second-born children, and that mortality rates drop significantly for subsequent children and remain lower until at least the seventh child.⁴² If rural families had fewer children, it is therefore unlikely that child mortality rates would be any lower. Hence the assumption that high child mortality is a direct result of high birth rates seems unwarranted.

d. Are families poor and malnourished primarily because of population growth?

In chapter one we saw that the percentage of families living under the nutritionally-defined poverty line has been increasing over the last decades. One may be tempted to conclude that this is due to growing population pressure for available food within the country. Yet this too is an inappropriate conclusion. For while the population has indeed doubled since Independence, food grain production has more than doubled during the same period. In fact, total foodgrain production per person has increased from 170 kilograms in 1950 to approximately

200 kilograms in 1978-79.⁴³ However, increasing income disparities between the rich and the poor have meant that *accessibility* to such food by the poorer half of the population has been decreasing. "Too many children" in itself, cannot be the cause of malnutrition and increasing impoverishment in the country. Instead, it seems we must examine the economic structures and policies which determine the maldistribution of food and all other resources.

Furthermore, it can be argued that rural families have the number of children they do because they *need* them. Children are, for the landless and minimally-landed families, their *only* source of security — not only for parents in old age, but also for the *immediate* security of the family unit as a whole. Young children often become an economic asset to a family long before their nutritional needs represent an unmanageable burden, as is clear from Rakku's story. And families must hope for sons because daughters will be 'lost' to the family after their marriage. The economic value of children to labouring families in Tamil Nadu was most vividly demonstrated during the severe drought in the mid-1970's. During this period of acute unemployment, the earnings of children who had jobs in local match-making and fireworks factories became an even more precious — and in many cases, sole — source of income for the poor. This message, to be sure, is not lost on the labouring families!

Likewise, the tragic plight of the elderly, left without sons to care for them, is evident even to this day. On several occasions in Madurai, project workers witnessed elderly poor people, with easily treatable illnesses, die alone and unattended in their mud homes, simply because there were no surviving children/grandchildren to care for them.

Mitra can thus comment: "Few people at current levels of poverty, in rural and urban areas, can afford to remain unemployed for even a whole week. There are times when child employment substitutes adult employment... It is difficult for a poor family.. to perceive.. how fewer children can mean anything but a lessening of its strength in the struggle for existence. More children, especially sons, still mean a *net inflow of wealth*."⁴⁴

Mitra also points out that this economic contribution of children has been actively and systematically ignored by national and international Family Planning agencies. "Certain areas of (Family Planning) investigation became inconvenient or embarrassing or pointed to the need for a more complex package of social and economic programmes... (and) were not given the weight they deserved... (Thus) the country

was denied a continuous account of vital perspectives on the value and cost of children."⁴⁵

It has been estimated that an Indian couple must bear an average of 6.3 children in order to have a 95% certainty that one son will survive until the father is 65 years old.⁴⁶ Kaur observes that "it is interesting to note the close correspondence of the actual marital fertility for India and that predicted by the statistical model."⁴⁷ But it is also true that individual families cannot plan in terms of *averages*, for they know that childhood deaths strike in a fairly random manner. Village women vividly express this uncertainty: "It's impossible to calculate how many children a woman must bear! Some families lose five children, some families are lucky and lose only one or perhaps even none."

Clearly then, until the poor of India possess guaranteed and regular employment as an alternative to the frail but sole security that children now represent to the majority, the idea of limiting family size to numbers that are, in the abstract, "demographically sound" for the country as a whole, is entirely irrational, indeed suicidal, for individual families.

e. Would better health care encourage smaller families?

Two common views regarding Third World health care continue to dominate population thinking. One view, the more enlightened, suggests that improved health care would lead to population control because parents, knowing that their children would survive, would then choose to limit their family size. The second view is that efforts to improve child health are only misguided kindness — that children of the poor must be allowed to die. Otherwise, "nature's balance" will be even more "upset". Improving child health standards would only compound the global population problem.

Both views utterly fail to understand the economic and social reality of the poor, and therefore the reasons why the 'problems' exist in the first place. The "nature's balance" position is mentioned here because it is a view which is still surprisingly alive in the west, the assumption being that the number of children poor families have is arrived at by chance and is a result of uncontrolled reproduction. Yet, as we have seen, this is simply not so. As an ultimate solution to population growth, the "nature's balance" view is meaningless. Unless childhood mortality rates were very much higher than the present 25 to 30%, parents will continue to replace those children lost to them. If anything, the continuing experience for couples of seeing some of their children die only motivates them to have an 'extra' child. The let-children-die position then is as superficial as it is humanly obscene.

But could improved child health care, on the other hand, be an ultimate solution by itself to population growth? Effective child health care would be an important initial step in reducing the number of 'extra' children born. Yet health care in itself does little to transform the primary economic need for children. If rural couples could somehow be guaranteed that all their children would survive, it is still unlikely that they could afford to limit family size to the "demographic ideal" of two children. The only difference, and an important one at that, though for moral rather than demographic reasons, would be that fewer children would die needlessly. At the same time, it can be argued that child health could never be adequately improved without fundamental social and economic changes, since the major causes of high childhood mortality are economic — malnutrition and the inability of labouring women to provide adequate care and food for their young children, or to take them for medical care when required. So to talk of radically improving child health standards through medical techniques becomes, in this sense, merely wishful thinking.

Throughout this section we have looked at population growth by focusing on the family as a unit. Yet if rural families generally limit the number of children born to them, this does not necessarily mean that the burden of such planning is equally shared by women and men. Once a couple attains a desired family size, it is mainly the woman who bears the on-going fear of further pregnancies, knowing that responsibility for additional children — or abortions — rests upon her. The physical risks and hardships for women as they resort to village-level abortions for unwanted pregnancies are predictably high. That women usually feel obliged to seek abortions without their husbands' knowledge reflects the oppressive degree to which their lives are controlled by men. This subordinate position of women also partially explains why the number of "official" abortions performed in medical institutions continues to be only a tiny proportion of the estimated total.⁴⁸ The reasons for this are several: transportation expenses, lost wages and a general suspicion of government Family Planning activities are all important factors. But it is also true that for most village women it is unthinkable for them to ask "permission" from their husbands to seek abortions at these centres, or equally as unthinkable for them to make such a journey alone under some other pretext. As a result, safer institutional abortions remain for the most part out of their reach. Thus, in the general effort to limit family size, women bear not only a *greater* burden than men, but in addition, an entirely *unnecessary* physical burden and this is so precisely because they have so little control over their lives, reproductive and otherwise.

Yet it is unlikely that labouring women, had they equal rights with men, would choose to limit family size to two children. For, given the existing economic conditions of increasing poverty and disparities, the same economic need for children would persist.

The factors which lead to continuing high population growth rates in the country are of profound importance. Some of these issues have been touched upon in these pages in order to examine a few of the superficial notions regarding child ill-health, mortality and family size — misconceptions which continue to dominate much of the official population and health thinking in the country. Without denying the existence of cultural and psychological factors, and their particularly devastating impact on women, this analysis emphasizes the primacy of economic factors in influencing family size. Clearly the present population growth rates cannot continue. But based upon an entirely different perspective of the "problem", that is, from the viewpoint of the common labouring family, an entirely different interpretation of the source of the problem becomes apparent. Through this re-interpretation it also becomes clear that radical socio-economic change offers the only possibility for "population control" — change in which the Indian agricultural labourer is no longer marginal and therefore powerless in society. By definition, such a societal restructuring which would guarantee the basic security of employment and food, would as well transform the distribution of health resources so as to make them serve the common man. To concentrate on reducing birth and child mortality rates before economic and socio-political issues are concretely addressed is to confuse and ignore the most fundamental questions.

The belief that "too many children" causes ill-health and malnutrition is more than simplistic. The fact that such thinking persists is a profound reflection on the ideological base behind official health and development thinking as a whole.

NOTES

1. P.G.K. Panikar observes that "child deaths account for over half of deaths in the country" (in "Resources Not The Constraint on Health Improvement: A Case Study of Kerala", *Colloques Internationaux du C.N.R.S.* No 582 — *Asie du sud, Traditions et Changements*, p. 551). 53.25% of all village deaths occur in children under 5 years, as reported in *Sample Reg. Bulletin*, Oct. 1975; and in *Measures of Fertility and Mortality in India*, SRS Analytic Series, Health Division, 1981.
2. "Vital Statistics, Births and Deaths", Statistics Canada, Health Division, 1981.
3. The term refers to the most severe form of malnutrition/emaciation, where other

- specific diseases have not by chance intervened to be officially noted as the "cause of death"
4. Very occasionally, measles can cause a serious brain infection, even in the well-nourished child, which is the primary reason, measles immunization is given in the affluent countries.
 5. A useful measure of the effect of poverty on birth weight is the "Socio-Economic Birth Weight Quotient" — a ratio between birth weights in lower and upper socio-economic groups in a single country (X 1000). The quotient is reported as 869 in Bombay and 916 in Madras, and indicates a major difference between lower and upper classes. On this, see D. Jelliffe, "The Socio-Economic Birth Weight Quotient", editorial in *Envir. Child Health*, Vol. 23, No. 5, Oct. 1977.
 6. A recent study of women construction workers in Andhra Pradesh found that "more than half of the respondents worked till the day of delivery and resumed work after three or four weeks" (in K.M. Manohar, et al, "Women Construction Workers", EPW, 1981, p. 81).
 7. See *Nutrition Atlas of India*, National Institute of Nutrition, 1974. "Severe malnutrition" refers to children weighing less than 60% of the average weight of well-nourished children; and "moderate malnutrition", between 75 and 60%.
 8. *Nutrition in Punjab*, Punjab Nutrition Development Project, Government of Haryana, Chandigarh, 1974.
 9. *Health for all*, op. cit., p. 51.
 10. Ahluwalia, N.S., Cassen, R. et al. "India: Occasional Papers". *Staff Working Paper No. 279*, World Bank, May 1978, pp. 185-91.
 11. "Calorie Intake According to Land Ownership", *Nutrition News*, Vol. 3, No. 2, National Institute of Nutrition, 1982.
 12. "Percentage of Rural Population Below Prescribed Calorific Intake in Different Expenditure Classes (1971-72)", *Behavioral Sciences and Rural Development*, Jan. 1980.
 13. Sommer, A., Loewenstein, M., "Nutritional Status and Mortality", *Amer J Clinical Nutrition*, 28: March 1975, pp. 287-92.
 14. *Survey on Infant and Child Mortality*, 1979, Office of the Registrar General, Ministry of Home Affairs, New Delhi. This is not to suggest, however, that the child mortality of the urban poor is necessarily lower than that of their rural counterparts. It would well be that the high health standard of the middle and upper classes in the urban areas, and the concentration of the country's elite (and wealth) in the cities, counterbalance to a great extent the mortality of the urban poor within the general figures. According to the *Health for All* document, "available data on urban slums show that malnutrition there is no less than in rural areas" (op. cit., p. 40).
 15. Curiously enough, although in the same survey, Fertility rates were extensively examined in relation to individual family income/per capita expenditure, the Report fails to provide similar data for mortality rates. Rather, it chooses to relate mortality to less clear (that is, indirect) socio-economic indicators such as household lighting.
 16. Pillai, K.N., Namboothri, N., "Caste, Status and Fertility in a Rural Area of Tamil Nadu", *Bulletin of the Gandhigram Inst. of Rural Health and Family Planning*, Vol. II, No. 3, July 1972.
 17. op. cit., pp. 266-67.

18. Ibid, p. 25.
19. Dutta, B.N.D., et al: "A Longitudinal Study of Morbidity and Mortality Pattern of Children under the Age of Five Years in an Urban Community", *Ind. J. Med. Res.*, 57, pp. 948-57, as reviewed by K.E. Vaidyanathan in *Studies on Mortality in India*, Monograph Series No. 5, The Gandhigram Inst. Rural Health and Family Planning, 1972, p. 235.
20. Saxena, D.N., *Social Context of Fertility and Family Planning*, chapter III, as reviewed by K.E. Vaidyanathan (1972) Ibid, p. 158.
21. Sinha, G.P., Ranade, S.N., *Women Construction Workers*, ICSSR, Allied Publishers, 1975, p. 11.
22. On this, see "Health Statistics", Government of India, Delhi, 1981, pp. 24-5.
23. This is based on experience not only in Tamil Nadu. Arole also reports TB as "number one killer among India's adult population". See R. Arole, "Community Health as a Tool for People's Organization", in *People's Participation in Development*, ed. W. Fernandes, Indian Social Inst., 1980, p. 29.
24. As reported by the Director-General of the Indian Council of Medical Research, "Indian Scientists Abroad respond to ICMR call", IE, Dec. 16, 1981. The estimate of 5 lakh TB deaths is probably low. TB in young children is rarely diagnosed as such, but plays a very significant role in mortality in young children. From my experience in Tamil Nadu villages, a rough estimate would be that at least one child death per village each year would be due to underlying TB infection, though the immediate cause of death would be recorded as "cough", malnutrition, or even dysentery. If this is the case generally in the country, perhaps an additional 5 lakh deaths would be attributable to TB.
25. Jelliffe, D., Jelliffe, P., *Human Milk in the Modern World*, Oxford University Press, 1978, p. 201. ("In the 1920's it was still customary for pediatricians to recommend semi-solids only at the end of the first year.")
26. Tapioca, a staple in Kerala, is perhaps the one exception.
27. In their study of family income and nutrition in a Tamil Nadu Village, Djurfeldt and Lindberg severely criticize the inadequacy and ideological base of current nutrition education thinking. They examine the position of a prominent nutrition expert in the country, quoting him: "Feeding programmes have to be integrated with other health and welfare programmes to form a composite package programme... Nutrition education at various levels is perhaps the only way to cultivate the right type of food habits and motivate a judicious expenditure of food budgets within the economic framework of the different segments of the population." Djurfeldt and Lindberg comment: "Here is an example of bourgeois ideology in the field of nutrition. As if by magic, and under cover of scientific authority, ideology here tries to cover up the relation of malnutrition and disease to poverty and economic structure. We are asked to accept inequality and exploitation and to 'motivate a judicious expenditure of food budgets within the economic framework of the different segments of the population'. In the name of 'realism' a quixotic programme of nutritional uplift is suggested. Bourgeois development policies proclaim radical transformation of the economic structure to be impossible, and propose more 'realistic' programmes, which are incapable of attaining their professed goal. They prefer using pills against poverty instead of trying to abolish it." (op. cit., pp. 83-4).
28. op. cit., p. 104.

29. in "Health Behavior of Rural Populations: Impact of Rural Health Services", EPW, 1973, p. 2263; emphasis added. See also, D.N. Kakar, "People's Perception of Illness and Their Use of Medical Care Services in Punjab", *Ind. J. Med. Education*, Vol. XI, No. 4, Oct.-Dec., 1972; T.N. Madan, "Who Chooses Modern Medicine and Why", EPW, 1969, pp. 1475-84.
30. op. cit., p. 181.
31. Ibid.
32. For details, see Appendix III.
33. Pursuing a deeper understanding of the reasons for population growth takes on an even greater significance in the face of the persisting belief in compulsory sterilization as an answer to the "problem". For example, an ex-president of the All-India Obstetrics and Gynaecology Congress has been recently quoted as suggesting that "legalized compulsory sterilization is the only method of controlling India's rapidly growing population" (in *The Tribune*, Dec. 30, 1980, as reported by Satyapal Dang, *Mainstream*, Jan. 17, 1981, p. 7).
34. The current (6th Plan) Family Planning outlay makes up more than one third of the total health allocation (cf. footnote 6, chapter 3).
35. *Sixth Five Year Plan*, op. cit., p. 19.
36. See for example, D. Banerji (1982), op. cit.: D. Banerji, "Family Planning in India: The Outlook for 2000 AD", EPW, Nov. 30, 1974; D. Banerji, "Political Economy of Population Control in India", in *Poverty and Population Control*, ed. L. Bondestam, Academic Press, 1980; G. Djurfeldt, S. Lindberg, "Family Planning in a Tamil Village", in L. Bondestam, *Ibid.*: E.D. Driver, *Differential Fertility in Central India*, Princeton Univ. Press, 1963; M. Mamdani, *The Myths of Population Control: Family, Caste and Class in an Indian Village*, Monthly Review Press, 1972; D. Mandelbaum, *Human Fertility in India*, U. of California Press, Berkeley, 1974; A. Mitra, *India's Population: Aspects of Quality and Control*, A Family Planning Foundation/ICSSR Book, Abhinav, New Delhi, 1978; M.V. Nadkarni, "'Overpopulation' and the Rural Poor", EPW, 1976, pp. 1168-72; M.V. Nadkarni, "'Overpopulation' and the Rural Poor: A Rejoinder", EPW, 1978, pp. 1115-17; S.K. Rao, "Population Growth and Economic Development: A Counter-Argument", EPW, 1976, pp. 1149-58; Marika Vicziany, "Coercion in a Soft State: The Family-Planning Program in India", Part One, "The Myth of Voluntarism", *Pacific Affairs*, Fall 1982, pp. 373-402, and Part Two, "The Sources of Coercion", *ibid.*, Winter 1982-83, pp. 557-92.
37. Important regional differences do exist. These overall data also tend to obscure recent changes in particular States and/or population subgroups. For the purposes of this chapter however (ie. examining a number of common misconceptions regarding reproductive behavior, as opposed to presenting a thorough demographic analysis) I have chosen to consider overall data for the country. Some discussion of regional differences is given in chapter seven.
38. *Sixth Five Year Plan*, op. cit., p. 374.
39. See S.K. Rao, op. cit., and Gupta and Malakar, "Fertility Differentials with Level of Living and Adjustments of Fertility Birth and Death Rates", *Sankhya*, 1964. Dietrich also notes that agricultural labourer households in the East Tanjavur area averaged 2.3 to 2.4 surviving children; fewer than for landowning families in the same villages (in *Religion and People's Organization in East Tanjavur*, Christian

- Literature Society, Madras, 1977, p. 121).
40. Mandelbaum, op. cit., p. 71. In 1966, the Ministry of Health estimated that 15% of all pregnancies are terminated by induced abortion (cf. "Report of the Committee to Study the Question of the Legalization of Abortion", New Delhi, 1966). One study however, has found a figure as high as 30.4% (cf. "A report on the study of the incidence of abortions in a weaver community in the project area", *Bulletin of the Pilot Health Project, Gandhigram* 4(3):24-30). By comparison, only 2½ lakh abortions (or less than 1% of the estimated total) are currently being performed in the government/public health institutions annually (in "Misuse of MTP in name of Family Planning denied", IE, Feb. 27, 1982). Therapeutic abortions were legalized in 1971, but facilities are still mainly available in larger urban centres and a few of the Primary Health Centres.
 41. *Ibid.* p.8. In 1980-81, three million sterilizations were performed, mainly vasectomies, in the official Family Planning programme. However, a Karnataka study has found that the mean age of vasectomy acceptors is 39 years, and the mean age of the acceptors' wives, 31 years and these couples had an average of 4.3 surviving children. This would suggest that sterilization is adopted more as an alternative to traditional Family Planning methods once the desired family size is achieved, rather than as a choice to reduce family size. On this, see N. Baskara Rao, *Family Planning in India: A Case Study of Karnataka*, Vikas Publishing, 1976. Banerji also points out that "more careful and independent studies (of the effect of vasectomy camps) indicate that in over 60% of the cases, the performance of vasectomy was of little demographic significance" (in op. cit., 1974).
 42. S. Kaur reviews various studies of child mortality by birth order, in *Wastage of Children*, Sterling Publ., New Delhi, 1978, pp. 206-8.
 43. On this, see *Manorama Yearbook*, 1981, and K. Dandekar, EPW, p. 772.
 44. A. Mitra, op. cit., p. 720, emphasis added.
 45. *Ibid.* p. 629. Several recent studies in Nepal and Java/Indonesia reveal that "households with greater numbers of child-producer units are economically more efficient. The positive relationship between the total work-input of children in a household and its economic efficiency is relatively independent of its access to land". See, M. Nag, et al., "Economic Value of Children in the Peasant Societies", Paper No. 1.3.1., for International Population Conference, IUSSP, Mexico, Aug., 1977, as quoted from A. Mitra (1978), op. cit., p. 629.
 46. May, D.A., Heer, D.M., "Son Survivorship and Family Size in India — A Computer Simulation", *Population Studies*, 22, July, 1968.
 47. S. Kaur, op. cit., p. 12.
 48. See footnote 40.

CHAPTER III

The Health Care System

We have looked at the economic base of the lives of the labouring rural poor, and how this poverty directly influences both their health status and access to health care services. The next step in the analysis considers the structure and assumptions of the existing health care system and how its very organization affects its utilization by the people whom it is intended to serve. Admittedly, this approach does not emphasize the significant scientific achievements of the major medical institutions in the country, nor the valuable services which many of the urban hospitals provide. But a village perspective is warranted because of the lack of such a viewpoint within current health analysis. Though this chapter is critical, it is clearly appreciated that the ultimate source of the problems which are highlighted in these pages, lies beyond the medical profession and the health system itself. In later sections, such specific criticisms will be placed within a broader and more useful framework.

First, let us briefly trace the historical origins and development of the health care system.

1. Historical Development

The first modern medical college in India was established in 1835, "when the attempts to train medical staff in the indigenous systems alongside European ideas were swept away as part of the general change in official (British) policy". The number of colleges was gradually increased to twenty-two during the colonial period. The pattern of care provided by these allopathic doctors (British and Indian) reflected the needs of the colonial power; that is, care for the British administrators and army officials, but also gradual extension of these services to the Indian educated elite who participated in the administration of the colonial government and the Indian army.

The pattern of private practice also developed from the British model. As Jeffery observes: "Most doctors went into government services until about 1900, by which time there were sizeable numbers

of independent practitioners (at least in Bombay and Calcutta). The top positions in government were dominated by British doctors in the elite IMS (Indian Medical Service) right up to Independence, and until the first World War they dominated private practice in the major towns as well".² Long before Independence, the medical profession became concerned about the squeeze on the market of ill-health by the increasing numbers of trained physicians. Jeffery indeed notes that "it is possible to point to concern being expressed from the early 1920's at the effect of 'overcrowding' (that is, competition among private doctors) on the ability of doctors to practise 'scientific medicine'".³

So the dual pattern of the British model — that of government service and private practice, was well established during the colonial period itself. Jeffery draws attention to the key role of the British Medical Council and British Medical Association in determining this model transfer. But he also points out that "the long-run success of the British model can be attributed to the fact that the Indians who were recruited to the IMS and who occupied the top positions after 1947 were thoroughly convinced of the validity of the British model. The main criticism of the Nationalists was that Englishmen should not man all the senior positions".

Colonial health policy placed primary emphasis on the establishment of urban, curative hospitals. What public health measures were adopted were mainly focused in the urban areas as well. Some British and Indian officials were, however, concerned about the neglect of health care for the masses of the population, especially in the rural areas. In 1946 the Bhoré Commission drew up a detailed health report which subsequently became the framework for national health policy after Independence.⁴ Plans for the new rural health care system were innovative and bold, envisaging a massive extension of primary curative and preventive services. Yet, in their essence, they simply added a rural dimension to the curative, physician-dominated, urban pattern of services which had developed over the previous century of British rule. Although the government took on the hiring of some doctors to staff the public centres, the fundamental assumptions of private practice were not challenged, let alone critically examined. Nor were structures ever adopted to ensure a massive and necessary re-distribution of health resources and man-power throughout society. As a result, the proposed reallocation of health resources to the rural areas came to be progressively watered down in subsequent Five Year Plans. As well, through pressures from the profession and politicians, the up-grading of professionals to international (that is, "Western") standards continued to dominate health training.

Thus, two quite separate systems of health care evolved — one, urban and curative, consisting of expanding numbers of hospitals in the major towns and cities and consuming most of the national health budget; the other, a network of Primary Health Centres serving the rural 80% of the population but in effect divorced from the urban system.

2. Distribution of Health Resources

Before looking in detail at rural and urban health services, it will be useful to consider how health resources are distributed generally between the rural and urban areas. To appreciate the urban bias in government health funding, let us look at the last several Five Year Plans.

Rural versus Urban Expenditure

The Central government has allocated 1.9% of the total Sixth Five Year Plan budget to health and health-related services.⁶ This does not include the Family Planning allocation which represents an additional 1.04% of the budget. But how much of these funds are specifically channeled to the rural health system — that is, to the network of 5,400 Primary Health Centres (PHCs)? Unfortunately, figures for direct PHC expenditures are not available in the Sixth Plan document. However, looking back at the previous plan, it can be calculated that the annual expenditure for each PHC was about 2,83,000 rupees; that is, almost three rupees per villager. In 1977, Rs. 12,000, or 4% of this amount, was allocated to medicines, while most of the remaining budget represented staff salaries and transportation expenses. At the same time however, the *total* national health expenditure amounted to twelve rupees per person.⁷ These figures indicate that a very large portion of health funds is taken up by urban institutions (that is, by hospitals, training, research and administration).

Various estimates in the past have suggested that three-quarters of the health outlay is concentrated in urban areas.⁸ It is probably closer to two-thirds, considering that a significant proportion of the funds for "communicable disease" control is allocated to the rural areas. Even then, remembering that 80% of the population is rural, the urban: rural distribution of health resources is heavily weighted in favour of the urban sector.

Health Personnel

After Independence the number of medical colleges was increased rapidly so that today there are 106 medical colleges which graduate

more than 11,000 doctors each year. Most of these colleges are funded by the State or Central governments: the remaining few are privately run.

In spite of the great numbers of doctors being trained, largely at the expense of the state, only 20 to 30% of all doctors are working in the rural areas; and of these rural doctors, many are in private clinics, and therefore often inaccessible to poorer families.¹¹ Three-quarters of all doctors remain in the cities and larger towns where only 20% of the population lives. A revealing summary of the rural:urban distribution of health resources and personnel is given in the following chart:

Health Services in Rural and Urban India¹²

	Rural	Urban
Population	80%	20%
Doctors	20%	80%
Hospital Beds	17%	83%
Protected Water	4%	90%

In the light of this urban and private-practice bias in the distribution of doctors, it is interesting to compare PHC expenditures with the public funds channeled to the training of doctors. It is estimated that the government spends about Rs. 1,50,000 to train each medical graduate.¹³ At the current output of doctors, this amounts to an annual expenditure of approximately Rs. 165 crores — representing a sum of almost 2½ rupees per person in the country each year. At the same time, however, PHC funding amounts to less than 3 rupees per villager annually. In effect, then, the government has been spending as much on training doctors, the majority of whom go into private urban practice, as on direct funding of the entire PHC system!

Inequalities WITHIN the Urban sector

But considering even the urban areas which are highly 'doctored', what is the distribution of health care between the poor and more affluent socio-economic groups?

Only thirty per cent of the country's doctors are working in the public sector; the remaining are either in private sector employment or in individual private practice.¹⁴ In addition, in a number of States many public appointments are part-time — the doctors working in the public

hospitals in the mornings, and in their private clinics in the afternoons and evenings.

Furthermore, control over who is admitted even to publicly-funded urban hospitals is, at least to some degree, in the hands of individual doctors who are heads of hospital departments. While it is true that poor individuals who are gravely ill generally do get admitted as Emergencies, it is also well known that many Department chiefs determine a significant number of ward admissions from their own private practices.¹⁵ This added pressure on bed-space and general care further distorts whatever care might be available to the poor majority who cannot afford initial "private consultations". A study of the distribution of public health services in West Bengal¹⁶ in the early 1970's reflects this class bias within the public urban hospital system. The study found that the poorest 50% of the population represented 56% of out-patient visits, but only 33% of hospital admission days. On the other hand, the next 30% of the population, representing the urban middle class, made up only 26% of out-patient visits but 49% of hospital admission days. It appears then, that even the services of the small proportion of doctors working in the public health sector are skewed in favour of the less in need.

The overall maldistribution of doctors and health resources is not unique to India. It is a classic pattern in many of the non-socialist Third World countries. India is only more dramatic because of the numbers involved. Yet this contradiction has been made even more poignant in recent years by the seemingly paradoxical unemployment of doctors. It is estimated that there are now 20,000 unemployed doctors in the cities, and a similar number of "under-employed".¹⁷ Yet it is hardly a lack of disease which is the problem. Rather, much of the population is excluded from the "health care market" because they are simply too poor to afford such care — or afford access to such care. The unemployed-doctor paradox then, is one of appearance only. In fact, as we will look at more closely in later chapters, it is a predictable outcome of the market forces operating in the field of medical services: distribution of medical care based on the ability to pay (since the majority of doctors are in private practice), rather than on need. It is hardly surprising then that medical training and care becomes geared to the needs of the wealthier and healthier(!) sections of society.*

In the next two sections of this chapter we will explore what this

* A similar contradiction exists for food distribution: buffer stocks and the exporting of food when a large proportion of the population cannot afford to buy even minimally adequate food.

overall pattern of health resources distribution means in terms of specific medical/health services available to village families.

3. Rural Health Services

The rural health system is based on a network of Primary Health Centres, approximately one PHC in each of the 5,200 rural Blocks. Each PHC serves a population of approximately 1,00,000, and is staffed with two to three doctors and a team of twenty to thirty paramedical workers. Many of the paramedical workers are designated as field (village-level) workers, including up to eight Auxiliary Nurse-Midwives/Maternity Assistants posted at Sub-Centres within the Block: there were 51,184 such Sub-Centres in 1981. The PHCs are the focus of preventive care as well as simple curative care. Theoretically, more complex health problems are referred to the District hospitals in the towns and cities. The average distance from any particular village to the PHC is between ten and fifteen kilometres.¹⁸ The distance from a village to a hospital for referral care is estimated to be from forty to sixty kilometres depending on the State.

The services offered at the PHC include basic curative care: simple antibiotics, vitamin tablets, cough mixtures; as well as midwifery care and simple surgical procedures such as vasectomy operations, draining abscesses, etc. The field working staff are responsible for public health measures in the villages such as anti-malaria work involving the collection of blood smears, distribution of Chloroquine tablets, and DDT spraying of village homes; and until recently, regular Smallpox vaccination. The Maternity Assistants/Auxiliary Nurse Midwives are responsible for maternal and child care — providing expectant mothers with Tetanus Toxoid immunization and iron tablets, as well as DPT immunization and Vitamin A drops to young children. In addition, between one third to one half of the paramedical workers are solely involved in Family Planning promotion, although in the mid-1970s the remaining PHC staff were also assigned monthly Family Planning recruitment quotas.

From the standpoint of national planners and health advisors the design for rural health services appears as a logical means of extending basic health care to the rural population. What the design looks like from the standpoint of the labouring village family can however often be a very different story. It is a profoundly revealing reflection on the system, and the planners of that system, that a clear analysis from the perspective of the labouring villager is unavailable. Let us therefore put ourselves in the shoes — or barefeet, of the villager.

Response to Health Priorities

In assessing the relevance of the rural health system it is necessary to consider what problems the PHCs are set up to deal with. Several of the more important causes of childhood mortality, such as tetanus of the newborn, are clearly recognized among the activities of the PHC staff; yet many of them — for example, dehydration, malnutrition, measles, and tuberculosis — are not. Looking at the leading cause of death in the country, diarrheal dehydration, it is surprising that although the doctors at the PHCs are able to diagnose such dehydration (indeed, a traditional village midwife can as well), rehydration facilities are not routinely available at the health centres. And yet the technique of intravenous rehydration is relatively simple. In fact many young doctors graduate from seven years of training, unskilled in a method¹⁹ that is taught even to paramedics in some Third World countries, such as Tanzania.

Likewise, at many PHCs TB is neither routinely diagnosed, even though many cases would require only a sputum analysis,²⁰ nor is it generally treated. In Southern Tamil Nadu at least, tablets are usually dispensed only if the patient has first had a complete checkup at the District hospital. But even then, Streptomycin, an essential drug in the treatment of advanced adult cases, has often not been available through the PHC. The diagnosis and treatment of TB in villages is instead left to a District Team — a small 'mobile' TB team responsible for the entire District population of two to three million villagers! This is all the more remarkable when TB is probably the leading cause of death in adults up to the age of 65 years.

There are of course logistic problems in making any of these treatments available. The purpose of discussing these issues is not simply to find fault, but rather to look carefully at the ways in which the health system fails to meet *primary* needs of most rural people. When dehydration is by far the leading cause of childhood mortality in the country, it is an astonishing reflection on health system priorities that rehydration is not routinely provided at the PHCs. In fact, perhaps the main reason such in-patient facilities are lacking is the unwillingness of many PHC doctors to reside at the PHCs — even though government-built quarters are generally available. Procedures such as intravenous therapy, though basic, would require a 24-hour staff presence.

Economic Barriers

An even more important factor in determining the usefulness of the PHC system is the fact that most labouring families cannot avail its

services unless a family member is literally dying. For symptomatic treatment or preventive care, the journey is unthinkable in terms of lost wages and transportation costs. In this sense, since the PHC has little emergency life-saving value, it becomes almost irrelevant to their needs. Not surprisingly, many studies have shown that the great majority of those who do make use of the PHC services come from villages within a radius of only a few kilometres from the centres.²¹

In recognition of the need for village-level activities the PHC paramedical workers have been given the role of extending basic preventive services to the village communities. And in several specific areas, such as Smallpox vaccination and Malaria control, the effect of their activities has been considerable. Even before the WHO-assisted Smallpox Eradication Programme of the early 1970s, several States, particularly in South India, had succeeded in eradicating Smallpox simply through the PHC field workers' regular vaccination work. But at the same time it is important to recognize that these successes were possible because of the *technical* nature of the task; in the case of Smallpox only a relatively small proportion of the population needed to be reached to break the chain of disease transmission in a given region. And a single vaccination would provide three years of protection, or more. Also, one of the main target groups were newborn children, an easily reachable group because even labouring women are available at home for at least a short period after giving birth.

But Smallpox is unique in the general strategy required for its control. Most cases of death and ill-health, however, are *not* amenable to such a whole-population strategy. Instead, they depend on each individual being reached, often on a number of appropriately timed occasions, for that one individual to be protected. Tetanus of the newborn is a typical example. The only way a newborn baby will be protected is if *its* mother has received several doses of Tetanus Toxoid in the last half of her pregnancy. That particular mother must receive the immunizations and at specific times. Similarly, a young dehydrated child must receive specific treatment immediately or it will not survive.

Poverty, however, is not sensitive to these requirements of disease prevention. It is not economically possible for most working women to be at home when the PHC field worker makes his or her occasional visit. Most of these women will have left for field work long before. And for smaller villages, those not on direct bus routes, such visits are quite irregular indeed. Nor is it likely that field workers would often be present when a young child suddenly develops dehydration, even assuming they were trained in methods of rehydration.

The Barrier of Alienation

But the barriers to PHC utilization are more than just physical distance. As a recent ICSSR Report states: "An expert committee appointed by the Ministry of Health and Family Planning in 1973 to examine the full utilization of existing beds in PHCs observed that apart from West Bengal and Kerala where utilization was 50%, in states such as Punjab, Rajasthan, Uttar Pradesh, Madhya Pradesh, and Jammu and Kashmir, it was hardly 5 and 15%. The reasons were apathy of the staff, the status barriers between the doctor and the people of a low socio-economic group, and absence of a lady doctor".²²

The problems steaming from poverty are thus compounded by another problem — that of the almost total alienation of the educated and urbanized health staff from the villagers. The unwillingness of doctors to live and serve in rural areas is a widely recognized problem in many countries. A frequently suggested solution is the training of large numbers of auxiliary paramedical workers who will substitute for doctors in primary care and refer on more serious illness. But the assumption that paramedicals necessarily will be less alienated from the rural people deserves some re-thinking. For many paramedics are as reluctant as doctors to be in a village setting.²³ It is the rule rather than the exception that the PHC doctor in southern Tamil Nadu commutes back and forth each day from the closest town or city to avoid the lack of amenities of village life. But it is equally true that, whenever financially possible, the paramedics commute from towns as well.

The alienation of health professionals from the common villager is both cultural and economic. It is cultural because, by their participation in a modern, predominantly urban education process, they undergo the transformation of perspective that comes from "having made it", having an education and, at least potentially, an economic security that is based on a degree rather than manual labour. This elitist position in society creates a sense of pride and a dissociation from rural life, and from what is then considered backward and lacking in prestige. D. Banerji rightly stresses that "Because of their urban orientation rural health workers... have a strong distaste for rural life. *This distaste is for the entire way of life and not simply for the very poor facilities there* (the usual explanation cited). Health workers therefore tend to keep a distance from the rural population as a whole"²⁴

Furthermore, the education process creates the aspiration to provide at least the same advantages for their own children, and hence the desire to live in cities where "better" (often meaning, private)

education is available. Thus, the dissatisfaction of paramedics with being posted in rural areas is generally no different from that of doctors. But because of their greater dependence on government employment (compared to the possibilities of private practice for young medical graduates) and their lesser political influence, more paramedics than physicians end up taking jobs in rural areas. Rakku's reaction to the woman health worker, draped in starched white sari and carrying an umbrella to shade her skin from the darkening rays of the sun, is typical. Her vague resentment reflects the cultural distance between labouring villager and health worker — cultural alienation.

But the economic alienation is equally as devastating. To be a government servant in the Third World sets an individual apart from the rest of society in a way inconceivable to an outsider. A *guaranteed* monthly income places such a worker in an entirely different life situation from the rest of the labouring population whose lives are hand-to-mouth. This is true even for the quite modestly paid paramedical workers. The preciousness of their regular salaries can only mean that their first allegiance is not to the villagers whom they are intended to serve, but to the system that provides their monthly income. Villagers are naturally envious of this economic security which they can never dream of for themselves. They are aware too of the workers' external allegiance, and cannot help but be suspicious and even resentful.

The economic gap — a gap which in terms of security is not measurable in rupees, compounds the cultural alienation which the health workers' training has created. But the final blow to trust between villager and health worker is Family Planning promotion. In its continuing effort to control population growth, the government has set monthly sterilization quotas for all PHC health workers. If a worker fails to obtain his or her quota of Family Planning acceptors his salary is cut by a small amount. (Many workers in southern Tamil Nadu have simply resolved themselves to the lower basic salary). At the same time, however, no such quotas have been set for *health* promotion services, such as Antenatal immunization. The message is hardly lost on the villagers.

For the average labouring family children represent the only wisp of security for their lives. For this to be threatened by the health workers' promoting of Family Planning — and this promotion coming from workers who are enviably secure themselves — is often the "last straw" in breaking any bond of understanding or trust between them. Preventive services, such as DPT and Tetanus immunization, have

thus been tainted by the forced eagerness of the field workers for sterilization recruitment. Villagers have come to view most health services with the suspicion and negative feelings they have for Family Planning, and therefore tend to reject both. This unfortunate situation has been documented by many observers²⁵ and needs no elaboration here.

The effect of this cultural, economic, and Family Planning (!) alienation of the rural health workers from the poorer majority of villagers leads to their services being monopolized by the elite minority of village households. As Banerji points out, "the overall image of the ANM or LHV (Lady Health Visitor)... is that of a person who is quite distant from them (the poor) — meant only for special people or for those who can pay for her services. She is not for the poor"²⁶

It is unfair however to place 'blame' for the inefficiency and bias of the rural health services on the shoulders of paramedical workers alone. For the administration of health services hardly encourages alternative responses from them. The work relations and functioning of the health bureaucracy, as of any government bureaucracy in the country, are rigidly hierarchical, a colonial legacy which is vigorously maintained to this day. Sitting at the bottom of this hierarchy, the rural health workers are themselves often subject to oppressive working conditions from those above them. One single example is the inordinate pressures all paramedics now face to fulfill Family Planning quotas. They in turn often respond by re-directing this pressure (and coercion) onto those villagers who can least resist it, that is, the poor. Since power and control come solely from above, personal and political patronage abound. During the Smallpox Eradication programme in the 1970s, I witnessed paramedical workers in U.P. regularly delivering sacks of grain to their superiors, Deputy or District Health Officers, in order to "protect" their jobs from bogus charges as grounds for dismissal. Female workers in addition not uncommonly risk sexual harassment and exploitation, both by rural elite and bureaucratic higher-ups. As such, the bureaucratic structure is entirely incapable of fostering sincere or innovative service from the village-level workers. And those who try usually meet with frustration if not actual harassment. Why such oppressive, at times even despotic, relations persist and flourish is a question which sheds light on the distribution of power between classes throughout society.

Considering then all of these barriers, what is the rural health system able to achieve? The PHC provides simple curative care for some of the villagers who live in its immediate vicinity, perhaps 15% of the 1,00,000 population it is intended to serve. PHC activities have also

contributed in major ways to the eradication of Smallpox and to varying degrees to malaria control. Yet Maternal and Child Health services and the anti-Tuberculosis and Leprosy programmes have been of minimal effectiveness in terms of coverage and disease control. The Sixth Five Year Plan for example reports that only 17% of expectant women (four million) are receiving Tetanus Toxoid immunization, and 5% of children under five (six million) are protected with three doses of DPT.²⁷ And it is reasonable to presume that a large proportion of these mothers and children are either from urban communities or the better-off sections of the villages. Likewise, the plan reports that only 20% of leprosy cases are being effectively reached; it is estimated that there are more than four million leprosy cases compared to 1.5 million in 1947.²⁸

It is also estimated that only 18 to 30% of all TB patients in the country are currently being diagnosed. Of those diagnosed, perhaps only one third are actually able to complete a minimum of nine months treatment, while another third manage "two to three months of treatment and then give up"²⁹ A recent report from the Director-General of the ICMR admits that "in practice the (National Tuberculosis Control) programme has not taken off beyond the district headquarters and has not really reached the villages... Cases coming under the purview of the programme presently were rather minor ones while few positive cases were reporting for treatment".³⁰ What this information suggests is that the more severe cases of TB, which occur mainly in the poorer, undernourished portion of the population, are often missed by the existing services — again, a reflection of the economic barriers to health care accessibility. Suicide by villagers dying of TB continues to be a not uncommon phenomenon in Tamil Nadu; yet in most cases, resorting to suicide (usually to spare the family an economic burden) is based not on lack of awareness that treatment exists, but rather, on the realization that such care is simply out of reach economically for them.

What conclusions are possible then about the relevance of the rural health care system? Perhaps a general statement: that *the system is not organized to respond to many of the most basic health needs of the rural majority*; and furthermore, that *the common villagers' poverty prevents them*, through physical inaccessibility but also through economic and cultural alienation, *from making significant use of the services which are provided*. The fundamental problem lies in poverty which renders the poor unable to make effective use of the health system, and, as we shall consider in further sections, powerless to

pressures for changes in the services provided, or to insist on accountability from the system as a whole.

4. The Urban Hospital System

The publicly-funded hospitals are intended to provide curative and referral care for both the rural and urban poor. In what ways does their organization meet the needs of the villagers? Again, the story can only be told from the viewpoint of the villager. How does the system appear to him, work for him, when he or she tries to make use of it? To answer these questions it may be useful to look at one particular hospital. The hospital being described in the following pages is one of the major district hospitals in southern Tamil Nadu. It is also the hospital in which Rakku sought care for her child. While there may be slight variations, this basic organization of hospital services is probably typical of most government hospitals in Tamil Nadu — and indeed, in much of the country.

The Model and Its Assumptions

The model of hospital organization inherited by the Indian Government from the departing British in 1947 was a convenient one for the medical profession. In many States the practice of government doctors working only part-time in the public hospitals was retained, as was the custom then for doctors in the U.K. Thus it seemed logical that Out-Patient clinics should be run in the early hours of the day, usually from seven to nine or ten o'clock, followed by ward work or surgery until mid-day. Many doctors are then free to go off to their private clinics in the afternoon and evening; though in teaching institutions some of them do stay on to conduct special afternoon clinics.

In the hospital to which Rakku brought her child, all Out-Patient lab and x-ray investigations are carried out in the early morning. At nine o'clock a buzzer sounds to indicate that the services are closed until seven o'clock the following morning. Special procedures such as tuberculin (TB) testing or BCG are available only on particular days of the week, say Mondays and Thursdays, and so on. As one of the seven teaching hospitals in the State, this particular hospital also offers highly technical services, such as heart and neuro-surgery. As is common throughout the Third World, nursing staff is kept to a bare minimum, much of their traditional role being left with the family-attendant—whose presence is a pre-condition for hospital admission.

The Villagers' Difficulties

Having described the basic hospital system let us return to the

villager who brings a sick child for curative care.

For many, if not most, villagers it is difficult to reach the District hospital before the Out-Patient clinic closes at nine. To come the night before often means "camping out" in the streets, for the cheapest form of lodging is still too costly. Let us assume, then, that he has made the journey with a sick child the day before. When the child is seen by the Out-Patient doctor the villager may be handed two or three chits for testing of blood, or urine, and perhaps an x-ray if the child is especially ill. Amid the confusion of hundreds of other Out-Patients, the villager seeks out an attendant to ask where he must go for each of the tests; then, he struggles through the crowded maze of corridors and buildings, queuing up in long lines of similarly struggling and ill people. Each test sends him confused and overwhelmed to different corners of the sprawling complex. For the illiterate, the process is nightmarish. He is fortunate indeed if all these investigations can be completed before the morning buzzer goes off. For many, it takes a second, or even third day of queuing up. To compound the difficulties, some tests are only available on certain days of the week. He must wait, or return on that particular day. Only if the child is literally dying will it be admitted immediately. For in this hospital of fifteen hundred beds there are only 50 beds reserved especially for children.

The test results are only available the following day or later. He must again queue up at the different lab offices for these results, and only then return to the original Out-Patient area to present the sick child for diagnosis and treatment. Up to three or four days may have passed since he began the journey from his village. In effect, the villager is lucky if no tests are done — if symptomatic treatment is given immediately and he is sent away. Or if the child is dying, and is admitted that morning.

What does this system of hospital organization mean for the villager? What are its implications? First of all, if the patient is a man he may not only lose a number of days of wages, but his family must still eat and therefore he must borrow money to enable them to do so. Secondly, he must bear the expenses of travelling, camping out (with minimal facilities for bathing or latrines), buying food from local stalls and therefore incurring even greater debt. And thirdly, if prolonged treatment is required he must continually and repeatedly make the journey to receive his medications.

The villager who requires on-going treatment is given medicine for only a limited number of days. For blood pressure treatment, a three days supply of tablets is the maximum provided, and the patient is

expected to return every third day for continuing medications.¹¹ In fact, he often leaves the hospital never to return again. The villager diagnosed as having TB is expected to return every two weeks for re-issuing of tablets. Not surprisingly once there is slight improvement with an initial month or two of treatment, he often fails to return, leaving the medical officer grumbling about the stupidity of the villagers.

If, on the other hand, the sick villager is a woman or her young child, the camping out in the streets in itself prevents her from even trying to get initial treatment. What husband would permit his wife to be so exposed and humiliated? And if he were to accompany her, who then would look after the remaining family? Seeking care for young children and infants must be done by the mother in order to maintain breast-feeding; thus, the even greater barrier for women is equally as excluding for their young children.

The government claim of providing "free" health care is thus ruinously expensive for the average villager! In the ultimate analysis, the existing system is "free" only for the government for the rural poor cannot effectively use it. The unspoken assumption behind the present hospital system is that the poor have unlimited spare time — that their time is not important, and that they can afford many days for diagnosis and treatment. Perhaps "subconscious" would be a more appropriate word than "unspoken", for little thought at all seems to be given to the needs and constraints of the intended users of the system.

In fact, the reality is just the opposite. A villager's time is of critical importance because it essentially means work, and therefore food and survival. How is it that the educated do not know this, or choose not to think about it? The demands of the system on the villagers would be farcical if they were not so grossly unjust. For the system succeeds in placing curative health care almost entirely out of the reach of women and children. *It thus tends to exclude the group which is most 'at risk', most in need* — the very group which national and international conferences never tire of proclaiming "the future of the country".

At the immediate level, individual doctors and nurses can easily and rightfully say that they have "done their duty", as it is so defined by the existing system. Yet it is also clear that the system is failing to respond (and in many ways seems oblivious) to the needs and constraints of the labouring people. This leads us to a rather different interpretation of Rakku's story. This woman's struggle to save her child is exceptional. Her story portrays the obstacles a labouring family confronts

when it tries to make use of the existing health system. Most village women are overwhelmed by the binding economic barriers long before they think of going to the city hospital for care. Going to the city is a last resort which most village families are not able to even consider. The reasons are economic, but also lie with the organization of the hospitals, as we have seen.

Rakku is spurred by anger and by love. In her decision to take the child to the city she consciously risks the fragile security of her other children. She knows the meaning of losing her precious share of the harvest. She knows the grinding burden of accepting a greater debt for the family. She is personally filled with fear in going on her own to a strange city. And she is also dramatically aware that all these very real risks do not guarantee the survival of her child. In many respects her journey to the city is an irrational act. But it is true that a few village women are driven by love and despair at watching their children die, to struggle in this way. The act requires exceptional bravery and determination. And yet the response of the health system is one of disdain for not having brought her child sooner! For this labouring woman, this is perhaps the "ultimate insult".

What do the preceeding sections reveal about accessibility of health care for the common labouring family, and especially for that half of the population living below the poverty line? Clearly, what health resources and skills are available in the country are distributed greatly in favour of the urban areas, and within that urban population, greatly in favour of the more affluent elite who can afford to pay for private services and consultations. But it is not only poverty and ruralness which make adequate health services inaccessible. For the organization of the health system itself prescribes *additional* barriers which are devastating in their effect on the ability of the rural poor to use that system — for the two-thirds of the population for whom the public services are ostensibly designed. For the very structuring of urban hospital services compounds the problem of inaccessibility. It does this by essentially closing the doors of hospital care to most villagers. For by closing the out-patient departments in the early/mid-mornings — and by requiring many days for simple investigations to be done, as well as requiring a villager to return to the city every few days for medication—the system ensures that even the small portion (30%) of doctors working in the public health sector are that much more out of reach.

The glaring inequalities just described and our consideration of ill-health from the viewpoint of villagers raise three key questions. The

first is simply: Can this distribution of health resources and personnel be considered just? Does it reflect the "socialist pattern" of development espoused by national leaders at the time of Independence? The question is of even greater significance when it is remembered that the vast majority of the doctors in India are trained at the expense of the State; that is, *at the expense of the common people*. The second question asks: WHY has the health system developed in such a village-inappropriate way? Whose interests and needs is the present structuring of health services responding to? This leads to a final question: Could the outcome have been any different, no matter how innovative or radical the Bhore Committee recommendations, given the political context of India in 1947? The third part of this book will try to confront these issues.

NOTES

1. Jeffery, R., "Allopathic Medicine in India: A Case of Deprofessionalization?", EPW, 1978, pp. 101-113. And also, from this author, "Recognizing India's Doctors: The Institutionalization of Medical Dependency", *Modern Asian Studies*, 13, 2 (1979), pp. 301-26.
2. — in EPW, 1978, p. 102.
3. — *ibid.*, p. 109.
4. — *ibid.*, p. 105.
5. — *Bhore Committee Report of the Health Survey and Development Committee*, Ministry of Information and Broadcasting, GOI, Patiala House, New Delhi, 1946.
6. 6th Five Year Plan: Total Plan outlay = 97,500 crores
Health Programmes = 1,821 "
Family Planning = 1,010 "
- See *Sixth Five Year Plan*, op. cit., p. 58.
7. *Fifth Five Year Plan, 1974-79*, GOI, Ministry of Health and Family Planning, New Delhi, p. 2. Though not stated, this amount appears to include expenditures for the Subcentres as well.
8. *Sixth Five Year Plan*, op. cit., p. 366.
9. Some would argue that the urban hospitals serve the villagers as well, so that this urban bias is not as extreme as it appears. Yet an analysis of the children admitted in the southern Tamil Nadu hospital discussed earlier revealed that the majority come either from the city itself or from nearby villages. The *Health for All* document suggests that "only about 25% of all patients who come to urban centres are from the surrounding rural areas" (op. cit., p. 124).
10. D.L. Surendra, as quoted by D. Barreto, op. cit., p. 25.
11. Matthews observed that the services of local private allopathic doctors were sought mainly by higher caste and landowning families due to the "quite high fees" charged (op. cit., p. 147).
12. See D. Banerji, "Social and Cultural Foundations of Health Service Systems of India", *Inquiry/Supplement* to Vol. XII, June 1975; also, *Pocket Book of Health Statistics*,

- 1980, GOI, p. 70. In the past decade, the percentage of rural communities with protected water supply has somewhat increased due to recent government emphasis on village tubewell construction.
13. There are various estimates of the cost of producing a medical graduate. One study carried out by the Central Bureau of Health Intelligence has estimated the cost to be between Rs. 92,000 and Rs. 1,35,000, as reported in the *Hindu*, July 18, 1980. A recent statement by President Sanjivi Reddy puts the cost at "at least Rs. 2 lakhs" (cf. IE, "Reddy attacks poor health care", Jan. 21, 1982). On this, see also S.R.K. Gupta, "Putting the brain drain to work for India", *Yojana*, Jan. 1, 1981, p. 7.
 14. R. Jeffery, *Migration of Doctors from India*, EPW, 1976, p. 504.
 15. R. Venkataratnam, *Medical Sociology in an Indian Setting*, Macmillan, 1979, p. 52.
 16. T. Maitra, et al: "An Enquiry on the Distribution of Public Education and Health Services in West Bengal", *Sankhya*, Series C, June 1974; as reported by Pranab K. Bardhan, "On Life and Death Questions", EPW, 1974, pp. 1293-1304.
 17. R. Jeffery, 1974, op. cit., p. 504. In June 1981, the live registers of employment exchanges listed 14,800 doctors. See IE, editorial, Jan. 5, 1982.
 18. — Banerji, D., (1982), op. cit., p. 36.
 19. This is a particularly tragic example of the unquestioned transfer of western medical training to India. Intravenous rehydration treatment has generally been reserved for "specialist" paediatric training in western medical colleges.
 20. Recently, some effort has been made to provide a technician skilled in sputum analysis to some PHCS in Tamil Nadu.
 21. — On this, see C.S. Chuttani, "Factors Responsible for the Underutilization of Primary Health Centre — A Community Survey in Three States in India", *NIHAE Bulletin*, Vol. IX, No. 3, 1976; and the studies mentioned in "Health Sector Policy Paper", World Bank, 1975, p. 38.
 22. — *Status of Women in India*, op. cit., p. 121.
 23. — This should hardly be a revelation. Even under the scheme of training less qualified licentiate doctors in pre-independent India with the assumption that these would serve rural needs, it became evident by the 1920s that "licentiates were as unwilling as graduates to work in rural areas and that they were contributing to the glut of doctors in the towns" (Jeffery, 1978, p. 109).
 24. Op. cit., (1975); emphasis added.
 25. Banerji for example observes: "To a large section of the villagers, the inverted triangle and the workers behind this banner invoke a feeling of strong antipathy... The image of the Family Planning workers in rural areas is that of persons who use coercion and other kinds of pressure tactics and offer bribes to entice people to accept vasectomy or tubectomy." (in EPW, 1973, p. 2264). J.F. Marshall studied a U.P. village when an intensive Family Planning programme was introduced and remarked: "(There was) a pervasive belief that the entire Family Planning effort was untrustworthy and probably exploitative... All the lower-caste villagers knew that the Panchayat secretary... had effectively pressured six low-caste men (five of them over 60 years old) into getting vasectomy operations so he could meet his quota. He had not tried to exert pressure on the upper-caste men... Thus Family Planning meant to many of the villagers — especially the lower-castes — the possibility that some skulduggery was afoot." (in "Some Meanings of Family Planning to an Indian Villager", *Research Reviews*, U. of N. Carolina, Vol. 19,

1972, pp. 24-29).

26. in *EPW*, 1973, p. 2264.

27. Op. cit., p. 386.

28. On this, see "Sixth Five Year Plan", p. 370, and "India Today", Feb. 15, 1982, p. 123.

29. On this, see Ebrahim, C.S., *A Model of Integrated Community Health Care*, Prize winning essay of an international SIMAVI contest, 1975, p.29, and *Sixth Five Year Plan*, p. 384.

30. "Indian Scientists abroad to ICMR call", *IE*, Dec 16, 1981. The Sixth Five Year Plan adds that "nearly 2% of the total population in the country is estimated to suffer from radiologically active lesions (i.e. active TB)... The control measures adopted under the TB control programme do not appear to have made any appreciable dent on the dimensions of the problem." (p. 367)

31. — Officials fear that patients will sell their medicines if given in larger quantities; hence the policy of a maximum of three days' supply, even for chronic conditions such as hypertension. This may be so for some, no doubt partly in response to the debts incurred with coming for treatment.

PART III

Forces Shaping the Health System

Introduction

In part three, the focus of the book shifts from one of *describing* problems to instead, one of *exploring* why those problems exist. The forces in society which influence the organization and distribution of health resources are complex and not always apparent. Here, we will examine major forces in India which have helped to shape the present health care system, and explore the sources of resistance to a restructuring of national health resources which would serve the primary needs of the majority. In this, the analysis steps further away from Rakku's mud home. Yet the link between the struggle to save her child and these broader socio-political forces are intimate, as we shall see in chapter five. Understanding these links makes it possible to see why health services are structured as they are, but also leads to a re-interpretation of the very meaning of ill-health itself. It also brings into question the adequacy of liberal development theory, the assumptions of which continue to shape most health/development effort in the country. The final chapters of this section thus examine some of the inherent limitations of current primary health care approaches.

CHAPTER IV

Special Interests

1. Professional Interests and Assumptions

As the institutions of modern medicine took shape in pre-independence India, the Medical Profession adopted, along with scientific and technological principles, the attitudes and assumptions of its parent professional body in the U.K. Since Indian political leaders had accepted the principles and underlying assumptions of the British economic and political system, it is not surprising that they also held the same basic assumptions about the medical profession.

These assumptions are, for most doctors, ingrained and unthought. They include the following:

i. Control Over Health Care Services

- that, being a highly educated and skilled professional group, doctors will best understand society's health needs, and should therefore control to a major extent the shaping of health services.

ii. Individual rather than Societal Responsibility

- that a doctor's responsibility lies at the level of the individual. The doctor-patient relationship is not only inviolable but also exclusive. The implication is that the members of the profession need not take into account broader considerations of societal responsibility.

iii. Medicine as Private Enterprise

- that the profession, as a body, will defend its assumed right to use its skills in a private as opposed to a social context.

These assumptions deserve closer analysis. They in fact imply that the medical profession's interests take, and should be given, priority over the people's. Indeed, the preservation of health care in the realm of private enterprise is the core assumption around which the "profession knows best" cliché is built.

Some doctors may feel uneasy at seeing such assumptions written down in black and white. No doubt some of them would also genuinely admit that they hadn't thought about the problems of the rural labourer in this way before — that they were for example unaware of the barriers the health system imposed on the villager seeking hospital care. But having raised such questions, *could it be expected that the profession as a whole would allow the needed fundamental changes, let alone promote and take responsibility for them?* The fact that concerned doctors are unaware of the problems in the first place, when for a villager they are so overwhelmingly apparent, is a reflection of how removed the doctors are from the economic reality of their people.

While it is true that the autonomy of the Indian medical profession has been limited in certain ways by the government,¹ basic professional assumptions and "rights" remain unchallenged. For example, in India as in Western countries, the medical profession has consistently and actively stood in the way of structural changes within the health system. Examples are many. Recent ones in southern India include the continuing pressure upon the Tamil Nadu government to preserve the part-time rather than full-time appointment of doctors in public institutions, thus restricting general hospital services to the early morning hours. A more dramatic example is the 1978 state-wide strike by interns and young doctors in protest against the Central government scheme of training village-level health workers.² In both cases the State government has backed down in the face of such pressures from the medical profession, at the expense of changes intended to make the health system more relevant to the needs of the labouring majority. In acting like this, however, the Indian medical profession is only upholding the tradition of its parent bodies in the West.³

Control over health skills and information by the medical profession, takes on even greater significance in India where the gap between the "expert" (the technician) and the common people is even wider — economically, culturally, hierarchically — than in the industrialized West. The result is not only that basic scientific information (in *all* fields, not simply medicine) is denied to the common people, but also that its use is often inappropriate to their needs. This may be intentional: for example, the diverting of health resources to coronary care units, in response to political pressures and the needs of the elite. Or it may be due simply to ignorance: genuine lack of awareness about rural health priorities. The point, however, is that professional assumptions and influence make this appropriation of scientific information predictable.

But major forces beyond the medical profession itself have an interest in, and therefore play a role in, maintaining the present structure of the health system. Such forces include the commercial interests represented by the drug and medical technology industries; and also the upper-income classes which can afford the pampering services of private clinics.

2. Commercial Interests

The role of the medical industries in shaping official and public attitudes towards health and health care is important internationally, but it is especially visible in the Third World. The following section therefore considers the "business of health care", the development of health care as a "commodity."

Recent analyses have critically examined the methods and the effects of the multinational drug, food, and medical technology industries in the Third World;⁴ thus, a detailed study here is unnecessary. It will be useful however to look at several examples of these activities in India in order to highlight the relationship between the profession, the industry and the social-political system.

Infant Foods and Drugs

The relationship between the medical profession and the drug and infant food industries is intimate and dramatically complementary. And, as is true in the Third World generally, many of these companies are branches of trans-national corporations. The market for their products is enormous⁵ and is cleverly nurtured by slick and all-pervasive advertising which the large size and experience of the corporations make possible. Doctors are often beguiled by the publicity techniques: fancy packaging, glossy information folders, regular visits by ingratiating salesmen handing out free samples, prescription pads, free pens, and calendars with photos of fair-skinned chubby babies "nurtured" on tonics and milk powder formulas. Perhaps the ultimate symbol of the influence of the corporations on the profession is the mountainous displays of tinned infant milk formula which, until very recently, have greeted doctors as they enter national paediatric conferences. The contradiction represented by the infant food industry wrapped in the bosom of the paediatric community, when malnutrition and diarrhea are the leading causes of childhood mortality (mortality which is only compounded by the contaminated milk of bottle-fed infants), aptly reflects the dissociation of the profession and the health industries from the common people and their needs. The remarkable naivete of the medical community

with respect to the promotional methods of the infant food industry only highlights the enormous gulf which exists between the privileged lives of the health professionals and those of the common villager. This is not to say that there are no paediatricians in the country who recognize the negative effects of such promotion. There certainly are. But unfortunately their individual efforts have been no match as yet for the powerfully influential methods of the industry.

But it is not only the doctors who are beguiled. The corporations reach the public through the well-developed mass media of India with advertising which is extraordinarily effective on a population infinitely more "media naive" than in the industrialized West. The unsophisticated nature and gullibility of their vast audiences combined with the real fears and day-to-day struggle with illness create an unending heyday for drug and formula promoters. Virtually every newspaper, including the small vernacular magazines which are cheaply and mass-produced, reaches the remotest of villages and carries full-sized pages of infant food publicity. The Indian movie industry, largest in the world, participates as well — having access to illiterate audiences in palm-thatched cinema theatres throughout the rural areas. Beautiful and richly-saried actresses extol the virtues of tinned infant foods, various drugs and vitamin tonics — products which are expensive and generally offer no more nutritional benefit than simple village foods. For example, a single bottle of vitamin tonic costs perhaps three or four days wages for a labouring villager, whereas simple greens are available for only a few paise or even freely, and would provide the same or better nutrients.

Sadly, even the village labouring family can be won over by this promotion, and may squander precious saved rupees to buy such tonics and medicines for their children, believing them to contain some very special and unusual ingredients. For the mystique of what is urban and modern is devastatingly potent — to the extent that even the word "tonic" is now part of the rural vocabulary. Such pervasive advertising and promotion has gone essentially unopposed. In the past, official inaction has perhaps been as much due to lack of awareness of the problems by those in power as to intentional design; but due also to assumptions concerning the inviolability of the marketplace. The harmful effects at the village level are however very real. An infant whose mother is working in the fields all day may be bottle-fed with formula which is diluted often three or four times because of the cost. And instead of the traditional "sungoo" vessel — a small open cup for feeding liquids to young infants,⁷ a closed bottle

with rubber nipple is now commonly used. Boiling bottles to sterilize them is out of the question because of the cost of fuel, and lack of time and awareness. So the difficult-to-clean bottle invariably becomes a culture medium for the bacteria which cause chronic diarrhea in the infant. Particularly so, because the rubber nipple makes it possible for the mother or mother-substitute to leave the bottle for hours, prey to flies and sun, as it slips in and out of the child's mouth... The halls of the children's wards of government hospitals are thus lined with such emaciated bottle-fed infants. While superficial condemnations occasionally have emerged from the air-conditioned halls of nutrition conferences, the basic source of the problem has not been broached until very recently.

Within the last several years however, efforts by a local consumers group and IBFAN (the International Baby Food Action Network), have prompted the government to consider limiting the extreme forms of infant formula promotion in the country. In February 1980, the Ministry of Social Welfare constituted a working group, which included some members of the Indian Paediatric Academy, to draw up a code of infant food advertising. Yet, in early 1983, the code is "still lingering awaiting parliamentary enactment" ⁸ No doubt the official code will eventually limit infant formula promotion to some degree. But it is interesting to reflect on the tactics used by the industry — national companies as well as multinationals, to "water-down" the forthcoming code. And it is also revealing to look at the relationship of the medical profession, particularly the Indian Academy of Paediatrics, within this industry effort. As VHAI (the Voluntary Health Association of India) pointed out, the initial code which was recommended by the working group "tallies remarkably with that of the IFI (Infant Food Industry) lobby" ⁹ Only when members of the consumers group protested was the committee's attention drawn to the much stronger WHO code. ¹⁰

The close relationship between the medical profession and the drug/infant food industries appears in other forms. For example, well into 1982 almost two thirds of all advertising in one of the main Paediatric journals was for artificial infant formulas and vitamin tonics. ¹¹ As a recent analysis suggests, "the health care system (of Third World countries) have been heavily infiltrated by the (infant formula) industry. the invitations to dinners, the grants for research, the conference expenses and travel expenses paid for by the industry and a host of other gifts and services over the years have helped to soften up the acceptability of bottle feeding to the medical profession". ¹²

Obviously, not all products marketed by the medical industries are harmful. Some medicines, such as penicillin, are unquestionably useful. Many of these essential drugs however, could be produced and sold by a public drug company at lower prices. But there are a number of drugs on the market which are of questionable value, and some with clearly harmful effects. ¹³ One such drug is an anti-pyretic solution (an aspirin-like compound for fever) which is given by injection. The same drug could be taken as a tablet with exactly the same effect and for a fraction of the cost, thereby eliminating the very real and not uncommon side-effect of injection-site abscesses. The deep social contradictions within the market-shaped drug industry are reflected in the fact that, while 25% of the annual drug production in the country is taken up by vitamin tonics and nutrients, only 1.4% is devoted to anti-tuberculous drugs. As a result, such essential drugs as INH and Streptomycin (for TB) and Dapsone (for Leprosy) are in constant critical under-supply. It is estimated that production of INH and Dapsone is only one third and one quarter respectively, of minimal requirements. ¹⁴

Medical Technology

At the same time, there is enormous pressure from within the profession as well as from the medical technology industries for the government to establish highly specialized services in the urban centres — services such as coronary care units, Cobalt treatment facilities and even CT scanners. These services, which are exorbitantly costly to maintain let alone to set up initially, are of dubious life-saving capacity, and are inevitably available to only a tiny proportion of the population. The contradiction of high technology medicine in the Third World economies has long been evident; yet the very nature of current medical training and the attitudes it engenders make any real change in priorities unlikely. Nor can the individual doctor be blamed. Naturally enough, if medical education emphasizes advanced techniques, students develop interests in these technical fields and aspire to use this expertise. Moreover, *by its very nature the profession cannot be expected to transform itself into a social organization.* Such an expectation ignores its private-enterprise essence, and the market forces by which this essence is nurtured. For high technology medicine is, by definition, a very profitable business. Hence, the constant pressure from the medical profession for costly medical facilities. In truth, the medical gadgetry becomes a source of pride and self-interest equally to government officials, bureaucrats and the elite section of the urban communities who so benefit... We must therefore return to the basic question of whose interests are primarily being served by the

health system as it is presently structured.

3. Class Interests

Ultimately, it is government policy which determines the distribution of health resources within a country. This is especially true in India where the training of most health workers is funded by the State, and where basic curative and preventive services are also publicly funded. The skewed urban: rural distribution of health skills and funds and their profession-serving structures can hardly be considered accidental. Rather, government policy determines that it should be so, either through active decisions, such as purchasing CT scanners before reliable supplies of TB medicines or Polio vaccine are assured; or through non-decisions in critical areas, such as the continuation of part-time public appointments. Such policy decisions unambiguously reflect the priority which is given to the interests of certain sections of the population at the expense of others. For clearly the rural poor would not themselves choose to have eighty percent of doctors and health funding allocated to the urban centres and therefore out of their reach. Nor could they prefer that city hospitals be open only in the early morning hours. To suggest that the best interests of the majority are met by such government decisions is obviously contradictory. It is evident that urban and professional interests are given priority through not only the policy-makers' allocation of funding, but also through their failure to challenge the private enterprise assumptions and needs of the profession.

Likewise, the social contradictions represented by two standards of health care (private versus public) is repeatedly side-stepped in official policy papers. For example, the 1961 Mudalier Report concluded that "independent medical practitioners have to be considered as a separate entity (from the existing public system) whose efficiency should be preserved and whose legitimate interests must be protected". It suggests a gradual "transition" to a national health programme, adding that even then "some of the top-ranking specialists" should be excluded.¹⁵ One is left asking: "efficiency" for whom? and "legitimacy" of whose interests? This is, in fact, a remarkably frank statement revealing the preferential protection and legitimacy offered to particular groups in society by the official/ruling class.

It is clear that a solution to the gross inequalities in health care is not easy: nationalization of health services within the existing socio-economic and political order could bring chaos. But surely it is necessary to recognize why such a policy would be extremely difficult:

because the entire social order continues to enshrine and legitimate the interests of the elite, including professionals, over those of the masses.

But let us consider more precisely how the interests of the profession are served by the present organization of health services. These interests begin with the training of 11,000 medical graduates each year. Except for a handful of private colleges such training is fully funded by the Central or State governments. Families whose children are admitted benefit in several ways: First, through the obvious employment income benefits; and secondly, by virtue of the dowry-value of a son or daughter enormous in medicine. Through pressure from local elites the State and Central governments have been induced to set up a large number of medical colleges throughout the country. In the words of a past president of the Medical Council of India many of these newer colleges are "monuments to political influence". The State governments have obliged, until at present the "market" of ill-health in the urban communities is squeezed to the point of doctor surplus and unemployment.¹⁷ This is not to imply however that there is no remaining ill-health in the urban centres. The health status of the slum population which represents almost half the population of many cities, is perhaps no better than that of their rural counterparts. But extreme poverty generally prevents them from seeking care at the often underutilized private clinics.

In the face of this doctor surplus, staff appointments in public hospitals and health centres are convenient for several reasons. Firstly, doctors are provided facilities where they can make use of their highly technical training. Many institutions also offer opportunities for prestigious medical research. Secondly, such positions provide very enviable employment security, in addition to the public servant benefits which accrue. With the increasing surplus of doctors in the cities the government positions have become even more sought after by medical graduates. In most states there are waiting lists of several years, even for PHC posting. The latter are generally valued as a stepping stone — a necessary bitter pill — for obtaining a post-graduate seat or a direct appointment in one of the urban institutions.

Government funding of public hospitals and health centres can be re-interpreted then not just as a social welfare measure, but as a necessary adjustive mechanism which protects the interests of the medical profession itself. In effect, through the public hospitals, the government opens up the ill-health "market" — otherwise restricted because of poverty — to keep the free-market system of health care viable.¹⁸ At the same time this funding legitimizes the political system

by creating the illusion that planning priorities are primarily in the interests of the majority; though in fact, to channel less funds into public health services would be politically untenable.

But are there other reasons why government policy favours this special social group? For this favouring to "make sense" politically the predominant interests of those in official power must coincide with those of the profession. Such a mutuality of interests is understandable, for an analysis of politicians, government administrators and health professionals reveals a *common class origin*. What actually is meant by "mutuality of interests"? An understanding of the concept of social class is central to such an explanation. Put simply, social class means a sub-group within society, the members of which share a similar source of income and also a more or less similar level of societal *wealth, economic power and authority*.¹⁹

In what ways then, do doctors, politicians and government officials belong, broadly speaking to a similar class? Perhaps the answer seems obvious, but it is useful to look closely at the common links, particularly with regard to control over national resources — including health skills. One generally thinks of resources in terms of raw materials such as minerals, coal, and so on. But national resources also include land, irrigation, factories and mills; and as well, education, health care, and so on. The upper class in India can be identified as that privileged population group which directly owns such resources, or which controls their use and distribution through political or bureaucratic means.

For example, it has been estimated that less than one tenth of one percent of households in the 1960's owned more than half of all shares in industrial corporations,²⁰ a concentration of capital and power which has since then only increased. We also know that 60% of the land is owned by less than 10% of the population. The large landowning families thus belong to a small privileged group. Likewise, the 0.7% of the population who possess a university or technical education represent an elite group within society, since more than 64% of the people are still illiterate.²¹

Within the upper class however, there are major differences in the degree and nature of wealth and power. In fact, only a small sub-group with major financial and political powers — considerably less than 1% of the total population — constitutes the true "ruling class". In this sense, a distinction should be made between privilege and power. Yet the members of this ruling class generally come from upper class families and not from the remaining 90% of the population. And this is the case for doctors.

There are, unfortunately, few studies concerning the class background of doctors. One such study however, found that 88% of the doctors working at the All India Institute of Medical Sciences (AIIMS) came from urban families and that 69% of their fathers had college education.²² 96% of the AIIMS doctors were either from professional, business, government service or landowning families, and 71% enjoyed the very special privilege of private education. While the AIIMS represents perhaps the most elite among medical colleges, studies of the family background of students in other medical colleges reflect a very similar picture. Taylor's analysis of students in seven medical colleges in various states showed that only 35% had a rural background, and that 60% of their fathers had college education.²³ In other words, doctors not only represent a privileged group, but they also come from families, the upper class, which are equally as privileged.

Most doctors are moreover from higher caste families. For example, the AIIMS study revealed that 88% of doctors were from the Brahmin or higher non-Brahmin castes; similar Tamil Nadu²⁴ and Ghazibad²⁵ studies found 68% and 97% from the higher castes. This analysis will not attempt to discuss the relationship between caste and class, which is an immensely important, complex and changing aspect of Indian society.²⁶ Here, it is enough to remark that the upper-middle caste dominance in groups such as the health professions is a predictable outcome of the competitive economic system—a system in which the traditionally-dominated lower caste groups have been at an extreme and increasing disadvantage economically and therefore educationally as well.

The medical profession then, belongs to and forms one segment of the very elite section of Indian society, the same class which also includes those who determine national health policy.²⁷ This common class background makes it both predictable and understandable that the governing elite have the interests of the profession vividly in mind when shaping health policy. Two practical reasons however reinforce this "class affinity". Firstly, national health planners and government officials primarily belong to the urban, educated elite of Indian society. As such, they are more than adequately served by the health system just as it is. With numerous private clinics to choose from, and with incomes that make such services easily affordable, their every health need is amply catered to. And conveniently, the large public institutions provide the highly specialized medical technology which is often too costly for private clinics. There is therefore no direct stimulus from political leaders and parties for distributive changes in the system.

The second reason is even more fundamental. To question the basic "private-enterprise" and professional assumptions of the doctors and medical industries means to challenge the principles upon which their own membership within the elite is based. To give priority to the needs of the common people in a field such as health care would potentially bring into question *all* national policy, and hence, their own privileged position in society. This would include issues such as the continuing maldistribution of land, industrial resources and professional services such as education and law. In short, it would expose the need for a complete re-structuring of society—one that abandons the concept and reality of privilege. (Privilege, meaning an economic advantage and power which is legitimized by the political system and/or even guaranteed constitutionally). Clearly then, a re-ordering of medical priorities poses a comprehensive threat to existing class interests and powers throughout society.

At the same time, it is hardly useful to think of the present power structure, and of its policies, as a pre-meditated "conspiracy" by individuals within the elite. The existing problems and contradictions can only be usefully understood in terms of their being a *predictable* outcome of the socio-economic and political structuring of society—that is, of the social system itself. A social system can be broadly understood by looking at the assumptions upon which wealth and power are distributed, and upon which those in power act. We have already looked briefly at the assumptions of the medical profession. Similarly, by considering the rights guaranteed by the constitution, the priorities of the country's social system come into focus.

In India, as in many Western capitalist nations, the right to own land and private property is protected in the constitution. Yet other rights, such as the right to work and the right to feed one's children are not. The enshrined rights are of obvious relevance to the rich and educated within society. But for labouring families who own no property, and can never hope to, (and in some cases even forfeit the ownership of their own children through bonded labour contracts) these rights have little meaning. Likewise, "freedom of the press" is of little relevance for the 64% of the people who are unable either to read or write.

Such constitutional rights and freedom are useful and convenient for the already privileged, but almost meaningless for the masses of the poor in their day-to-day struggle simply to survive. Between four and five million children die needlessly each year, the majority because their parents are too consumed in labour that feeds the rest of the nation to be able to feed their own children adequately and

because the most basic of health care is not within their reach. In any practical sense, the rights enshrined in the constitution and which therefore shape the socio-economic system, do not touch their lives.

It is no accident, then, that a social system which fundamentally accepts and defends the concept of privilege (that is, selectively protects the interests of the upper class minority), can equally accept a skewed distribution of health services. The interests of the medical profession continue to receive greater priority because those who are in power and who determine health policy, represent the same class, share the same interests, and mutually want to maintain them. These are class interests, groomed and nurtured within a class system, in which the advantaged believe and act to ensure that it is their right to preserve their privileges before any other right or responsibility within society. *That such a class exists and has the power to do so is an inevitable result of the socio-economic and political structure of society.* The next chapter will thus place the reality of ill-health within an analysis of the economic and political order as a whole.

NOTES

1. See R. Jeffery, "Allopathic Medicine in India: A Case of Deprofessionalization?", *op. cit.*
2. "General Hospital Medics on Strike", IE, Jan 28, 1978. It is worth pointing out that this resistance was not primarily motivated by criticism of the scheme itself; but rather, out of a perceived threat to employment possibilities for young doctors. The similarity of this resistance from the profession in India, to medical profession resistance to the training of "nurse-practitioners" and midwives in a country like Canada, is striking. The February 22, 1981, *Sunday Standard* also reported a strike by 7500 doctors in West Bengal in which one of the demands was the "withdrawal of community medical service courses".
3. A few examples include: the Saskatchewan doctors' strike in Canada in 1962 in protest against the proposed provincial health insurance scheme (see, R. Badgley, S. Wolfe, *Doctors' Strike: Medical Care and Conflict in Saskatchewan*, Macmillan, Toronto, 1967); the present massive resistance by the American Medical Association and the associated medical industries against a national health service in the U.S.; and the direct role of the Chilean medical profession in helping to overthrow in 1973 the popularly elected Allende government which, among other social measures, was attempting to re-structure health services into a more just and public system (see, "Allende's Chile: A Case Study in the Breaking with Underdevelopment", in V. Navarro, *Medicine under Capitalism*, Prodist, 1976, pp. 33-66).
4. See for example, A. Chetley, *The Baby Killer Scandal*, War on Want, London, 1979; L. Doyal, *The Political Economy of Health*, Pluto Press, 1979; S. George, *How the Other Half Dies: The Real Reasons for World Hunger*, Penguin Books, 1976; T. Heller, *Poor Health, Rich Profits: Multinational Drug Companies and the Third World*, Spokesman Books, 1977; C. Medawar, *Insult or Injury?: An Enquiry*,

- into the Marketing and Advertising of British Food and Drug Products in India and Malaysia, Indian Social Institute, New Delhi, 1981; and D. Melrose, *Bitter Pills: Medicines and the Third World*, OXFAM, Oxford, 1982.
5. Investment in the pharmaceutical industry has increased from Rs 10 crores at the time of Independence to Rs 450 crores in the mid-1970's (cf. J.P. Naik, *An Alternative System of Health Care in India*, Allied Publ., 1977, p. 4.).
 6. M. Silverman reports that while in the U.K. there is one drug company salesman for every 20 doctors, in many Third World countries there is one for 3 to 5 doctors (in "The Epidemiology of Drug Promotion", *Inter, J. Health Service*, 1977, p. 162).
 7. This small vessel, used in southern Indian villages until recently, is open and therefore easily washed. And because it is round-bottomed, its contents cannot lie about but have to be immediately fed to the child, thus very much reducing the risks of bacterial contamination.
 8. *Health for the Millions*, Vol. VII, No. 5-6, Oct-Nov 1981, p. 24; and "Baby Milk Sales Soar as Indian Code Stalls", *IBFAN NEWS*, May 1983, p. 2.
 9. *Ibid*, p. 25.
 10. *Ibid*, p. 48.
 11. For example, 5 out of 12 full-page advertisements in the October 1981 issue of "Indian Paediatrics" were for infant formula and another 2 for vitamin tonics. The January 1982 issue had 6 of 15 advertisements for infant formulas, with 3 for tonics.
 12. A. Chetley, "Breast is Best: The WHO's International Code of Marketing of Breastmilk Substitutes", *IFDA Dossier* (International Foundation for Development Alternatives), 25:41-53.
 13. For an excellent account of harmful drugs and drug-combinations marketed in the Third World by some transnational companies, see D. Melrose, *op. cit.*, pp. 91-112.
 14. *Health for All*, (1981), *op. cit.*, p. 178.
 15. "Mudaliar Report: Report of the Health Survey and Planning Committee", August 1959 - Oct 1961, GOI, p. 135; emphasis added.
 16. "Outdated Models", *Times of India*, New Delhi, Jan 6, 1976.
 17. The president of the Medical Council of India estimated that by 1980 there would be 14,000 unemployed doctors in India (in Madan, *op. cit.*, p. 27). Jeffery speaks of a possible 21,000 (cf. above, p. 504).
 18. Recent demands by the Indian Medical Association for the government to nationalize health services can also be seen as a pragmatic suggestion for expanding the ill-health market.
 19. The following pages do not claim to make a scientific analysis of social classes in India. On this, see for example the forthcoming CSA booklet, *Classes in India Today*, Bangalore, 1984.
 20. C.T. Kurien, *Poverty and Development*, CLS, Madras, 1974, p. 53. The author quotes from the Report of the Committee on the Distribution of Income and Level of Living, 1974.
 21. *Pocket Book of Health Statistics*, 1980, *op. cit.*, p. 29.
 22. T.N. Madan, *Doctors and Society: Three Asian Case Studies*, Vikas Publ. House, 1980, p. 82.
 23. C.E. Taylor, *Doctors for the Villages*, Asia Publ. House, 1976, pp. 48-9.

24. See R. Venkataratnam, *Medical Sociology in an Indian Setting*, *op. cit.*
25. T.N. Madan, "Doctors in a north Indian city: recruitment, role perception and role performance", in Satish Saberwal, *Beyond the village: sociological explorations*, Indian Inst. of Advanced Study, 1972, pp. 77-110.
26. On this, see for example J. Maliekal, *Caste in India Today*, Centre for Social Action, Bangalore, 1980; and EPW, Special Number, 1979.
27. On the class background of politicians and administrators, see for example Ajit Roy, *Economics and Politics of Garibi Hatao*, Naya Prokash, Calcutta, 1973, pp. 12-43, and *The Illustrated Weekly of India*, Dec 28, 1980, p. 19.

CHAPTER V

The Economic and Political Order

We have looked at some of the major forces — professional, commercial and class interests — which have shaped the Indian health care system, and which continues to do so. Still, we must consider why continuing high levels of ill-health and mortality can be tolerated by the social order, and in fact, are compatible with the socio-economic system. And further, why an inadequate health system is accepted by the people themselves. The issue of acceptance raises two important questions: Why does the ruling class in India not NEED to be primarily concerned about the health status of the labouring poor? And why are the masses themselves unable to insist on a more appropriate system?

i. The Economic Order

Why is the health status of the labouring masses not of immediate or prime concern? This question is central because it reveals the position of the labouring masses in society. There is no primary interest because, within the existing economic order, *the health of the masses is simply not important*. Rural health is bad because the health of the labouring villagers is quite irrelevant to the process of capitalist production in India. Since there is a limitless reserve of unemployed or semi-employed, it does not matter if particular individuals are unhealthy, are unfit to work well or at all. For these individuals can and will be replaced. This then is the profound implication of marginality, which is defined by the present socio-economic order.¹

In understanding the fundamental *economic reasons* why the egalitarian-obvious is not done, a deeper interpretation of who and what is responsible emerges. Within an economic structure which by its very nature needs not, and indeed cannot, give value to the health of the labouring majority, it becomes meaningless and even silly to "blame" the medical profession or any other particular group for the inappropriate distribution of health resources. The medical profession, as Navarro points out, is only acting as co-manager of a health system, the basic structure of which is defined for it by economic and societal assumptions and forces which are much

broader than the profession itself.² This is not to suggest of course that the members of the profession, as also those of the elite generally, are not willing participants and beneficiaries of the existing social order (and therefore the "health/ill-health order"); they undoubtedly are, and as such, will fight to defend the privileges so defined for them by that order. Rather, it simply emphasizes that any realistic effort to change the present pattern of ill-health must be focused *at the same time* on the broader economic forces.

As one critic points out, "Health professionals generally take delegated power from other members of the corporate (resource owning/controlling) class. The latter comprise the same individuals and groups who hold economic and political power throughout the society, not only the health system... (Thus) the proper object of criticism and strategic action... should be the nature of the capitalist social organization rather than the medical profession".

This analysis refers to the U.S. but is equally relevant for the Third World countries which have adopted similar economic and health systems.⁴ Because of the greater disparities and enormous development problems in India, and in the Third World generally, the effects of such a control over health and economic resources by the few become even more devastating.

But if the marginality of the labouring poor renders their health status irrelevant, it also determines their powerlessness within society, and their inability to protest against their situation.

ii. The Political Order

The second question then that we seek to answer is: Why is the labouring majority unable to object to the present structure, control and distribution of health resources? Ostensibly, a government is responsible for channeling national resources to serve the needs of the people who have brought that government to power. Whether a government carries out a particular policy depends on the degree to which it feels pressure for accountability to the people as a whole (euphemistically termed "political will"). If there is no political accountability to ensure that the health needs of the majority are put above commercial and/or professional interests, the question is "Why not?"

The reasons for lack of effective pressure for change are complex. An understanding of this powerlessness requires consideration not only of the political/electoral system itself but also of the factors which act as specific deterrents to protest, such as the precarious survival of the poor, and the social forces which distract them from an awareness

of the root causes of their situation, or actively repress their efforts for change.

Odds Against Real Choice

In theory, India's parliamentary system of government distributes power equally throughout society by means of the democratic electoral process. Yet, as already pointed out, it is absurd to think that, if the poor majority had any real choice in determining the distribution of health resources, they would choose the existing system. For all practical purposes the rural and urban poor who comprise the majority of the population have no real power to pressure for and effect a redistribution of society's resources. This is so *in spite of* the existence of a parliamentary electoral system. Till now the masses have had only the possibility of choosing between national political parties, which represent the interests of capital and resource holders—whether the rural landed or the corporate elite. The casting of a vote has never held a real possibility of redistributing power from the members of the elite to the common people.

The reason for this is clear. To be capable of competing nationally, parties must be massively funded — just as in the industrial West.⁶ The chances that political parties which primarily represent the resource-controlling sections of society will attract funds and influence are remarkably greater than for any party genuinely standing for the poor. The contest is so "loaded" as to be essentially meaningless. This is why elections repeatedly produce victories for parties which favour the interests of the elite; a supposed electoral platform offers only a choiceless race to the poor.

A recent *Indian Express* article can therefore note: "The cost of fighting an election in the constituencies... was bound to be enormous... In addition, there was the illegal expenditure of the private armies that many candidates employed to terrorize opponents, from voting against them and to overwhelm and 'capture' polling booths, a practice that was not uncommon... In one particular State, not less than 30% of the legislators are involved in criminal cases of one type or the other" ⁷ The "criminalization of politics" in recent years has perhaps been the final blow to the notion of electoral representativeness. Another analyst comments: "The political process... assumes some of the attributes of organized crime. Even ten years back, people spoke disparagingly of politicians with criminal links. Now criminals have become politicians in some parts and are either the proteges or allies of politicians in others"

Desai thus concludes:

"Parliamentary democracy as a political institutional form has become objectively a shell, wherein the ability of the vast bulk of the people for self-determination has been transformed into its opposite... The social structure and the economic order which the parliamentary democratic form preserves, projects and coercively consolidates, is a capitalist order, wherein a small minority class owning capital, owning means of production, owning instruments of culture and propaganda, and also commanding resources to buy the electorate, also control political power. ('Parliamentary democracy') is basically a 'Bourgeoisie Democracy', a 'Democracy for the rich', wherein the blessings of the basic elementary democratic rights are inaccessible to the majority of the working people" ⁸

This lack of real choice means that the poor, as individuals, are unable to pressure for accountability from any particular government. This is so, and will remain so, as long as the labouring majority are unorganized as a class. It is true that the population was able, in 1977, to effectively register its opposition to coercive Family Planning policies. But it is important to recognize the limitations of this success. This protest could be successful because easing up on Family Planning promotion (at least the visibility of such promotion) would not affect the *immediate* personal interests of the ruling class, whose members dominate in all major parties. At the same time, the people remained powerless to force government to carry out any significant distributive policy.

As Navarro suggests, "politics in bourgeois democracies takes place in the realm of the politicians — the experts in the art of politicking, and not in people's every day lives. Thus the actual function of the electoral system is to legitimate the political process rather than to secure the people's input in their own governance".⁹ The "art of politicking" is vigorous in India where the business of electoral alliances and changing party allegiance reduces any potential meaning of the process to that of a plaything of the elite. Yet the illusion is generated that the primary interests of the common man are served by the political process. Such an illusion is a convenient and necessary way of preventing the dispossessed from becoming aware of the real source of their economic powerlessness, and in the fields of health, their unimportance.

It is true that there have been many individuals within the Indian elite who have had a broader social vision and have successfully

pushed legislation aimed at a redistribution of national resources. This is most evident in the land reform legislation enacted soon after Independence — legislation which at the time was among the most progressive in the non-socialist Third World countries. However, it is equally true that the reforms have remained frozen at the legislative level. It is estimated, for example, that by the mid 1970s in Tamil Nadu, only one percent of the land potentially available through the land ceiling had in fact been redistributed to the landless.¹⁰ The reasons are clear. The power to *implement* this legislation is vested with the elite who dominate the political and legal structures, and who often are, or at least represent, the landowning elite. It is well known that a significant proportion of the members of parliament themselves have landholdings in excess of the ceiling laws. This outcome then is predictable, for while land reforms have been legislated, any real power to *enforce* such legislation has not.

But the illusion of democratic input from the people must eventually wear thin. In southern Tamil Nadu some villagers are beginning to question the meaning of the electoral process. In the most recent national elections the proportion of voters was noticeably lower. One labouring woman in Rakku's village explained: "When you vote, your vote goes into a bottomless hole. As soon as you give your vote, the politician runs away with your trust. He forgets who you are. So now we refuse to vote."

Precarious Survival

Besides major obstacles within the electoral process, there are other factors which keep the poor from pressuring for change. One of the strongest barriers is the very fact of their destitution. So precarious are the lives of the families living at or below the poverty line that to *protest*, or to organize for change is, for the individual family, nothing short of suicidal. The poor simply cannot afford to set aside their daily work and wages to register protest of any kind; even less can they afford to anger those for whom they labour. And as Banerji observes, the situation is getting worse: "Because of deepening poverty, *people are becoming even more vulnerable* to control and exploitation by the ruling classes. Even those who were earlier economically independent are now being compelled to be dependent on them" ¹¹ The risks for women are even greater, involving not only their own well-being and their children's, but as well, the possibility of slander which, within a traditional social system, brings ostracism and even greater hardship.

As Alavi emphasizes, "the poor peasant...finds himself and his family totally dependent upon his master for their livelihood...no

machinery of coercion is needed by the landlords to keep him down. Economic competition suffices. The poor peasant is thankful to his master, a benefactor who gives him land to cultivate as a tenant or gives him a job as a labourer... The master responds paternalistically; he must keep alive the animal on whose labour he thrives."¹²

Thus, utter economic dependency shapes and reinforces social values. Cultural notions of hierarchy and fate come to offer the poor an "explanation" of their plight, without which their lives would be humanly intolerable. The role of socio-cultural values in lending stability to the existing social order is of obvious and enormous importance. We will wait to examine these issues in more detail, however, until later in the analysis when considering "underdevelopment" as a whole.¹³

Diversion

A third factor contributes to acceptance of the ill-health status quo. Both the mass media and populist political movements contribute to diverting the attention and frustrations of the people away from questioning or analysing the source of their oppression. In the realm of the media, rural cinema houses promote the economic status quo by extolling the traditional values of the existing social order. Modern movie stars who themselves often control economic and political life, are garbed in religious roles in an attempt to white-wash their dominance with a veil of respectability.¹⁴ The poor and media-naïve are taken in, and invest their votes in the imaginary heroes and gods of the cinema — a phenomenon hardly unique to India, as the most recent U.S. election demonstrates. At the same time, local politicians capitalize on regional ethnic differences and divert the frustrations of poverty and exploitation into populist cultural sentiments and regional language chauvinism. Social problems and enormous class disparities are glossed over as traditional and regional cultures are glorified. For it is fundamental that the masses not come to perceive the explanation of their misery in class terms.

Opposition to Change

Yet in spite of such enormous barriers local groups of rural poor throughout the country continue to organize and struggle for social change. What are the consequences of such protest?... Examples are many. Resistance to the organizing efforts of the poor are now becoming virtually daily occurrences, though only intermittently reported in the media. Such resistance comes from local village elites but is also often tacitly supported by local officials. Banerji documents

these tensions:

"This powerful grip of the affluent classes over almost all the facets of the lives of a substantial section of the population is by far the most outstanding feature of the way of life of the people in rural India. As this exploitative relationship is of considerable value to the political leadership at higher levels, the latter lend active political, administrative, "legal" and economic support to the exploiting classes in the villages in maintaining their grip over the poverty stricken sections. Respondents from the poorer sections in the (U.P.) villages... complained to the investigator again and again that the people of the upper classes kept a constant watch over the activities of those of the lower classes. At the earliest hint of any organized effort on the part of the poor to demand a better deal, the ring leader is identified and hired toughs are let loose on him... Such exemplary punishments strike terror in the hearts of the other members of this group and the lesson sinks in well. The police is on the side of the upper classes and it will not even report on such events. Even when such reports are made, witnesses will not be forthcoming to testify, while there will be plenty of hired witnesses who will testify to the contrary. And then, even when evidence is available and the judge happens to be fair and he convicts the accused, the rich have avenues of going on preferring appeals at higher courts."¹⁵

But such repression is not limited to the northern States. As one labouring woman from a village nearby Rakku's recently explained: "If we ask for higher wages, they will burn our village down (the Harijan colony), and put us out. Where would we stay and live? Then we would eat only mud. They will say, 'Without working for us, why do you want to stay?' — meaning that we are here (exist) only to work for them."

Increasing levels of repression in the rural areas is reflected in a recent report which noted that "while 6,197 cases of atrocities against the Scheduled castes were registered in 1976, the number rose to 1,32,426 in 1979"¹⁶ Yet it is only predictable that any such organizing efforts by the most exploited, even for small changes, will trigger desperate reaction from those who currently benefit from their dependency. For the very act of organizing by the poor represents a fundamental challenge to the "respect" and traditional authority of the local elite. The consequences of protest are predictably heaviest and most immediate for those who are oppressed the most.

The various forces which contribute to the passivity of the poor in the face of gross economic and health disadvantages each deserve a separate analysis which is not possible in this study of ill-health. They are touched upon here to emphasize that the acceptance of an unjust health system is not inexplicable. Rather, it is determined by specific and observable economic and social forces, and is therefore open to understanding and to change. And further, the reasons for acceptance by the poor are inseparable from the forces which lead to their exploited social positions. This broader perspective necessarily leads us to a re-interpretation of the very term, "ill-health"

NOTES

1. The relationship between marginality, underdevelopment and ill-health is looked at in greater detail in chapter 7, pp. 154-60.
2. V. Navarro, *Medicine Under Capitalism*. Prodist, N.Y., 1976.
3. H. Waitzkin, "The Marxist Paradigm in Medicine", in *Inter. J. Health Services*, 1979, p. 683.
4. On this, see for example V. Navarro, "The Underdevelopment of Health or the Health of Underdevelopment", in *Imperialism, Health and Medicine*. Baywood Publ., N.Y., 1981.
5. A modest estimate of election expenses per candidate speaks of Rs 15 lakhs (cf. "MPs seek more pay, perks", IE, Dec 13, 1981, p. 10).
6. "Politics now governed by money: B.K. Nehru", IE, Dec 24, 1981, p. 5.
7. See, K. Harlekar, "Ten Years to Chaos", IE Magazine, Jan 24, 1982, p. 6.
8. A.R. Desai, *State and Society in India: Essays in Dissent*. Popular Prakashan, 1975, pp. 102-3.
9. op. cit., (1976), p. 205.
10. G. Venkatramani, quoted by C.Y. Kurien in *Economic Change in Tamil Nadu*. Allied Publ., 1979, p. 201. As K.C. Alexander points out, the acts exempting temples and trusts in Tamil Nadu "proved to be a loophole for large-scale evasion of the land ceiling provisions. Many large landowners transferred their land into a number of fictitious trusts and continued to keep large holdings in the name of those trusts. As a result... between 1961 and 1971 there has been no substantial change in the extent of land under tenancy, indicating stagnant tenurial conditions" (in *Peasant Organizations in South India*, Indian Social Institute, New Delhi, 1981, p. 194). Another report suggests that of an estimated 52.3 lakh acres of surplus land in the country, only 39.3 lakhs have been declared surplus, 23 lakhs taken possession of, and 16.3 lakhs distributed (in *Link*, Sept 23, 1979).
11. in *Poverty, Class and Health Culture*... op. cit., p. 66; emphasis added.
12. H. Alavi, "Peasants and Revolution", in *Imperialism and Revolution in South Asia*, ed. K. Gough, Monthly Review Press, 1973, p. 333.
13. See the subsection, "The Concept of Underdevelopment" in chapter 7; and chapter 9.

14. Kappen comments: "Myth-makers use the media in ever more subtle ways to influence the minds of the people so that these spontaneously respond to the images and ideas suggested to them... Where political leaders are elevated to the status of mythical figures, whatever they say or do is automatically legitimated before the public. A further result is the de-politicization of the masses." (in "Culture and Class Domination", *Negations*, Jan. 1982, p. 10).
15. in *Poverty, Class and Health Culture...*, op. cit., p. 57.
16. "Hope out of suffering", *IE*, Jan 7, 1982.

CHAPTER VI

Re-Interpreting "Ill-health"

This study seeks to understand the reasons for continuing ill-health in India. In this search the story of Rakku has been an essential starting-point. For in understanding the life and social reality of this woman, and the majority of rural families whom she represents, the cloud that surrounds the 'problem of ill-health' begins to disappear. The factors which limit her family's health are readily revealed.

Rakku is unable to save her child because she is poor. Her poverty determines her inability to adequately nourish and care for her children; it also means that she cannot make effective use of the existing health system when her undernourished children are ill. More importantly, her poverty renders her powerless to pressure for changes within the health system which could make it more accessible and appropriate to her family's needs and thus to the needs of the majority. But most critical of all, she is equally powerless to confront the exploitative economic system which determines her family's hunger and dependency in the first place. This *powerlessness* then is the truer meaning of "poverty", for which ill-health and the lack of material possessions including minimal adequate food are but *symptoms*.

Is Rakku simply an unfortunate individual? Clearly, not. She represents most landless labouring families, the minimally landed, and the majority of unorganized wage labourers in the country. She certainly represents the 48% of families who are presently unable to maintain adequate levels of nourishment, families living under the "poverty line". And her children belong to the 60% of children under five years of age who are undernourished to the point where their bodies are less able to withstand common infections.

This is not to suggest that individuals from the elite do not also get sick. But the risk of the affluent actually dying, for example, of TB is extremely low compared to the under-nourished labourer. This is so for many reasons: a lower risk of exposure to the infection, adequate nutrition which enables the body to fight off or contain the infection,

minimal physical labour demands, and a vastly greater possibility of early diagnosis and treatment: This, compared to the observation that "more than half of the tuberculosis victims in (a Karnataka) district visited a government institution of western medicine... (and) were almost invariably dismissed with a bottle of useless cough mixture!"¹

It is not surprising then that the burden of ill-health primarily falls on a particular group of people in society whose bodies are weakened by inadequate food and inordinate labour demands, and who therefore succumb to common infections more easily — a group which is at the same time least able to avail itself of adequate treatment let alone preventive services. When we talk about ill-health this is what we must be referring to. And as we saw in Chapter 2, the few studies which have looked at health data by socio-economic class reveal exactly the expected pattern of increasing malnutrition and very much higher mortality rates in the lower socio-economic classes, whether urban or rural. So ill-health can and should be re-defined in a societal way — in truth, it is the state of belonging to a group or class in society which is "too poor"!

But at the same time as we talk of Rakku's poverty we also are obliged to look at the source of it. We have described this source as one of "exploitation"... But what exactly does the word mean? In Rakku's case it means that she produces food by her labour which in large portion is taken from her to feed other mouths while her own family remains hungry. Rakku, the brick-kiln worker, carries bricks which are used in building the walls of other people's homes, and for her labour she is paid a wage which will never allow her to afford a few of those bricks for sheltering her own family. The road-building Rakku helps to construct roads which are used by vehicles which she will rarely use and never own. And the cotton or silk which she grows and weaves, drapes backs other than her own. And precisely because she is so poor and belongs to such a mass of other landless labourers also seeking work, she is powerless to press for a wage which would allow her to adequately feed herself let alone her children. So for her labour she is given a share of the produce which hardly suffices to keep her fit enough to labour more and to produce children who will in turn replace her labour. The rest of the value of her labour is taken from her to feed those whose hands do not touch the mud earth. Exploitation in its simplest sense means that the fruits of one person's labour are taken by others. Furthermore, it is the present structure and assumptions of society which determine not only this exploitation and the consequent maldistribution of the nation's food, but the maldistribution of doctors and TB tablets as well.

Ill-health thus also means the state of being "exploited"! — and in this sense, must be re-interpreted not as a "problem" in itself, but rather as a *symptom* of deeper socio-economic injustice.

India can produce enough food to satisfy the nutritional needs of all its citizens.² In fact, the country now exports some food grains and increasing amounts of cash crops produced on land which could otherwise grow food for the people. The per capita medical expertise within the country exceeds that of many Third World countries³ — including some which, by a better re-distribution of societal resources (including medical expertise), are approaching the health status of the "industrialized" world.

In realizing that at least four million of the five million childhood deaths every year are easily preventable given a more just distribution of all resources, particularly food, ill-health can be further re-interpreted as a form of "institutionalized violence" in society. The assumptions and laws of the prevailing socio-economic order which lead to the maldistribution of all resources, are in effect the structures by which this tragic violence is institutionalized and carried out. The needless death of so many young children each year is only the outward expression of these rules.

In exactly the same way one can look at the reality of illiteracy in the country. The present rules and forces which ultimately control distribution of health resources, also determine that over fifty percent of the national budget for education has been channelled to post-secondary school education which benefits a tiny minority, while 64% of the people remain illiterate.⁴ In effect, the existing social order has thus institutionalized the "violence of illiteracy." Indeed, most "social problems" can be similarly interpreted.

But how does this quite different interpretation of ill-health fit in with current approaches to rural health in the country? In the following chapter we will examine concepts such as "provision of basic health needs" and "alternative health systems" from the perspective of this deeper meaning of ill-health. In doing so, we will discover that the theoretical assumptions which underlie most health care efforts in the country tend to legitimize the existing health system, and thus the health/ill-health status quo. It is important to understand how this can be so.

NOTES

1. D. Banerji, S. Anderson, "Sociological study of awareness of symptoms among persons with pulmonary tuberculosis", *Bull. WHO* 29:665-683, 1963. While this

study was carried out several decades ago, Banerji suggests that "similar results were obtained in a (more recent) intensive study... in seven states of the country" (in "Place of the indigenous and the western systems of medicine in the health services of India", *Inter. J. Health Services*, 1979, pp. 515-6).

2. The "average" person requires 600 grams of rice or other cereal per day, or 220 kilograms per year, to meet basic calorie and protein requirements. This figure represents a proportionate averaging of adult and child requirements, and amounts to 2200 calories per day. Total foodgrain production in India in 1978-79 was 131-137 million tons, representing 200 kilograms per person (see, *Manorama Year book:1981*, p. 404). In addition to foodgrains, significant amounts of milk, eggs, meat, fish and sugar are produced. Foodcrops account for only a little over 80% of the total cropped area; non-foodcrops, such as tobacco (for which increasing amounts of previously food-producing land is being used), and cotton account for the rest. Thus, it is reasonable to assume that even at the present relatively low levels of agricultural productivity, basic calorie and protein requirements for the entire population could be met if food were equitably distributed, and if conversion of food-producing land to cash crops were restricted.
3. The total number of doctors in India in 1979 was 178,000, giving a doctor: population ratio of 1 : 3622. The desired norm suggested by the Mudaliar Committee and by WHO is 1:3500 (cf. *Pocket Book of Health Statistics*, 1980, op. cit., p. 35).
4. 0.7% of the population have university or technical diploma education (cf. *Pocket Book...*, op. cit., p. 29).

CHAPTER VII

Sources of Legitimation

We have looked at some of the historical, socio-economic and political forces which have contributed to the shaping of the health services in India, and which continue to do so. The limitations of the system are apparent. How is it then, that the medical profession, and the health system as a whole, maintains unquestioned its image of legitimacy while failing to address health needs for which it has accepted responsibility?

Internally, the organization of health services remains essentially unchallenged because its structure reflects the interests of the ruling class, as we have just seen. But powerful influences external to the country also play a major, if by and large unappreciated, role in adding legitimacy to the present health system and its professionals. One such legitimizing influence is the concept and interpretation of health and disease dominant in Western industrialized countries — what can be termed the "*medical model of health*", a model of disease causation which focuses almost exclusively on the individual, as opposed to social, determinants of health and disease. A second source of legitimacy is the *international health agencies*: by emphasizing short-term technical assistance, the activities of these agencies tend to draw attention away from more fundamental issues. "Model projects", "package programmes", token changes in medical curricula, and so on, obscure deeper questions, and thereby leave the central factors determining ill-health unexamined. This selectivity of concern, by default, provides continuing legitimacy to the present system. A third source of legitimation is the underlying development theory which dominates official planning generally in the country — the *liberal development model*, which in its essence can be described as a "welfare" approach to social problems. When applied to issues of health care, the solutions proposed favour and legitimize a technical, often dependency-creating framework for action.

These three sources of legitimation are so important as to warrant closer analysis. In this chapter we will look at each separately. But it

should be clear that as approaches to dealing with social problems, they *all* reflect a particular conception of society — the individualist, capitalist social model, out of which they grew. Thus, the problems associated with the extension of the Western health care model to Third World countries must be seen in the context of the values, assumptions and contradictions within the Western social model as a whole.

1. The Medical Model of Health

In response to the increasing health problems brought about, and made more visible, by the Industrial Revolution in Europe, a practical and theoretical discipline of "social medicine" developed in the early and middle nineteenth century. Social medicine theory placed the understanding of ill-health within a societal perspective. While not ignoring the particulate factors in disease transmission (though in the beginning, unaware of specific bacteria), the advocates of social medicine saw economic and social factors as more important because they determined *which groups* within society were more likely to develop illness. Thus, they came to stress societal methods of prevention.

As an example, Virchow, on returning from investigating a typhus outbreak in southern Germany, recommended to the Prussian government various measures such as land reform, higher wages, job creation, and lastly, improvements in drinking water supply and general sanitation. Virchow had come to conclude that "poverty was the breeder of disease and that it was *the responsibility of physicians* to support social reforms that would reconstruct society according to a pattern favourable to the health of man... According to Virchow, the treatment of individual cases is only a small aspect of medicine. More important is the control of crowd diseases which demand social and, if need be, political action."¹

In the late nineteenth century the new scientific findings regarding bacteria led to the development of the germ theory as an explanation of disease causation. In the medical communities of the industrial West this theory came to dominate the analysis of health and disease. One of the results was the interpretation of disease causality within an increasingly *individualist framework*. Illness was to be primarily understood as the entry of germs or bacteria into a human body. Further research saw this as facilitated by a lack of specific nutrients. The new scientific medicine soon became enconced in the Western health institutions. In Canada and U.S. the 1910 Flexner report

heralded the establishment of rigorous, scientific (that is, based on principles derived from the germ theory) excellence in the study of medicine and interpretation of health and illness.

As useful as the bacterial understanding of infection became in such fields as surgery and control/treatment of many diseases, this individualist approach unfortunately came to overshadow the earlier perspective and understanding of health as primarily determined by social conditions and socio-economic organization. The belief soon became entrenched that the primary source of health for a society lays in individual "interventions" — that is, in individuals seeking treatments, whether injections, consultations, surgical procedures or vitamin tonics. The very concept of *health* came to be equated with *health care*, and thus "commodified" — that is, individualized and purchaseable. In practice, the notion of "public health" became more or less restricted to the distribution of health care to the poor — to those left out by their lack of purchasing power. It is this over-riding emphasis on *individual intervention* that is termed the "medical model of health". The model contained an implicit assumption: that an adequate quantity of such "interventions" could, and would, lead to health in society — indeed, was the source of health.

The professionalization and increasing commodification of health care gave enormous power to the medical establishment — the medical profession and medical industries. The medical model was thus convenient for the profession and commercial interests. But it is important to recognize *why* such an interpretation of health could be so successful. The over-riding emphasis on individual factors (such as germs, lack of particular nutrients, etc.) in disease causation, justified maintaining health and medical skills within an individualist, private-enterprise domain. The model, then, was ideologically compatible with the structure of Western capitalism itself.

This technical and individualistic interpretation of health however fails to take historical realities into account. It ignores the fact that the dramatic improvements in Western health status came about in the 18th and 19th centuries, long before most scientific medical discoveries or the existence of health "professionals". Among the factors responsible, two stand out. Firstly, increased food production and much more effective transport of food between regions and countries reduced mortality due to periodic food shortages and famine.² And secondly, important social and labour reforms in the later part of the 19th century and first decades of the 20th, as well as environmental measures, led to improvement in living standards

among the working class. Thus, the most significant drop in mortality rates in the West took place before the development of most vaccines, before the discovery and mass marketing of the "wonder drugs", including antibiotics, and certainly before the training of large number of doctors within the rigorous standards of Flexnerian medicine.

The major improvement in life expectancy since the mid-and late 1800s has been mainly a result of decreasing infant mortality. In comparison, life expectancy in adults has increased relatively little.³ Better community sanitation facilities were in part responsible for this fall in child mortality; but even more importantly, the better nutrition and general care that working class families were able to give their children. The social reforms in the later 19th century which reduced some of the more extreme forms of exploitation of women and children with regard to hours of work, working conditions, and wages, enabled working class women to care for and feed their young children more adequately. Mortality due to the common infectious diseases declined rapidly and, together with public sanitation measures, caused overall childhood mortality to plummet.

Dubos therefore writes: "The general state of nutrition began to improve and the size of children in the labouring classes to increase even before 1900 in most of Europe and North America. The change became noticeable long before calories, balanced diets, and vitamins had become the pride of nutrition experts, the obsession of mothers, and a source of large revenues to the manufacturers of coloured packages for advertised food products... By the time laboratory medicine came effectively into the picture the job had been carried far toward completion by the humanitarian and social reformers of the nineteenth century... When the tide is receding from the beach it is easy to have the illusion that one can empty the ocean by removing water with a pail."⁴ He continues: "The most effective techniques to avoid disease came out of attempts to correct by social measures the injustices and the ugliness of Industrialization... This achievement cannot be credited to the type of laboratory science with which we are familiar today. Rather, it was the expression of an attitude which is almost completely foreign to the modern laboratory scientist... (Such) success had been due more to zeal in correction of social evils."⁵ But it is also important to recognize that *much of the force behind this "zeal" for social reform came from the organizing pressure of the working class itself.*⁶

Tragically, the individualist conception of health is dominant in

India today, as it is in many Third World countries. That the medical model of health continues to dominate official thinking is significant for two reasons. First, this medical-technical approach cannot solve the major problems of ill-health in the country. And second, because of its scientifically compelling and therefore unchallengeable stature, it has successfully prevented well-intentioned health workers from re-interpreting ill-health and malnutrition as issues of poverty and socio-economic injustice. The prominence given to the medical model has made an alternative interpretation of ill-health almost unthinkable. The model thus legitimizes the technical and individualist thrust of the existing health system at the expense of a deeper, more critical structural analysis of society.⁷ At the same time it justifies attempts at shoring up the methodology and theory of the existing system by planning yet more "packaged" programmes, or by ordering the distribution of yet another nutrient among the people most "at risk" — indeed, a euphemism for the malnourished and exploited poor!

More recently, the growing costs of the medical care approach has led to the popularization of the concept of self-help care. To lessen the cost to the State, individuals are called upon to contribute to the packet of health care services, both preventive and curative. Yet again, the approach rests on the basic assumption that health primarily depends on individual services (whether institutional or self-help) rather than on social conditions and economic structures. This fundamental confusion between *health* and *health/medical care* is clear even in recent government documents. The 1975 Srivastav Committee Report for example states in its guiding principles for a new and more "appropriate" health care system: "Health is essentially an individual responsibility in the sense that, if an individual cannot be trained to take proper care of his health, no community or State programme of health services can keep him healthy. The issue is therefore basically one of education".⁸ But as is apparent from Rakku's story, the issue, on the contrary, is one of employment, adequate wages and thus food — an issue of basic social justice.

It bears emphasizing that the germ theory is in itself a landmark in the understanding of disease and disease control. But since the health status of a society is primarily determined by its social organization, its role in contributing to *health*, is very limited unless combined with much broader social change. The undue prominence of the medical model in the West, as in India, is an example of how particular interpretations of science and social reality can be influenced by economic structures and ideology. Clearly, the imbalance is not due to the germ theory scientific method, but rather to the socio-economic

structures and forces within which it is used. Within a future socialist organization of Indian society, the very real, though clearly defined, value of this scientific contribution will finally be realized for the benefit of all the people — as will also be the other indigenous health theories.

2. The International Agencies

The second source of "external" influence in contributing to the health system status quo is the role played by the official and voluntary international health agencies. I choose to write about such a role, appreciating how controversial these comments may be to many of those involved in agency work. But I choose to do so for several reasons. Firstly, because the effects of international agencies are rarely examined in a critical and public way, and therefore such an analysis is long overdue. Secondly, because the people whose lives are being affected by many of the agencies' activities deserve to have such an analysis brought out. And thirdly, because there are no doubt many agency workers who have themselves sensed such conclusions, dimly or clearly, and who have as yet not felt able to speak out in spite of their uneasiness. It is hoped that these general impressions will stimulate deep and open analysis as to what *ultimate* effect the activities of the health-related agencies are having on the societies in which they are working.

Any discussion of the activities of the international agencies must be prefaced with the recognition that, without doubt, their efforts are often based, at least at the individual level, on good intentions. This of course makes the analysis more difficult. But good-intent neither guarantees proper analysis and understanding of the roots of underdevelopment and ill-health; nor does it necessarily encourage examination of how the agencies' specific activities may be contributing to the fundamental causes of the problems.

Though at an individual level, health agency programmes and projects may bring immediate benefit to a number of local "recipients", or special skills to a group of trainees, the meaning of these particular "successes" *must* be weighed in terms of the overall effect of the agency's presence in a particular developing country. The inadvertent effects of the agency's presence are unfortunately rarely if ever considered. The unspoken assumption is that any "aid" is better than none at all.

My impression, however, is that in India these side-effects may, on balance, be more detrimental to the total "development process" than helpful. And this applies to official agencies such as UNICEF,

WHO, the world Bank, as much as to voluntary agencies — CARE, Save The Children Fund, and so on, to name just a few. Recent studies have critically examined the overall impact of various international aid/development schemes,⁹ and many provide disturbing evidence of ulterior political and economic motives. They therefore seriously question whether the negative effects of many of these activities are entirely inadvertent. A more detailed consideration of this question is included in Appendix III. But to date there has been little specific study of health agencies as such. This section is intended as a beginning.

It should be clear that a distinction is being made between "development" and "relief" programmes. The analysis which follows does not refer to relief operations in acute situations of disaster, such as famines, floods and refugee camps, where the absence of local resources and organization justifies an outside source of relief and "structure" for assistance. But such emergency situations must be distinguished from the chronic social problems existing within a society. With regard to the latter, superimposed patchwork schemes can often lead to the postponing, or worse, co-opting of the forces which are working for the required radical changes. For not only do externally-created schemes fail to solve the fundamental problems, but they also often create an additional dependency which leaves local communities and even nations more vulnerable to the control and manipulation of the "bigger brothers" internationally. In the process the society loses its control over its own social and political evolution. This question is thus raised more and more within India: "When a foreign funding organization provides these (development) facilities, does it not diffuse the pressure which the people would have otherwise mounted on their own ruling classes to fulfil these promises?"¹⁰

Simply by their presence then, and the built-in limitations of their analysis, the potential is enormous for international agencies to (1) increase the dependency of the poor, (2) contribute to the side-stepping of fundamental causes of poverty and ill-health, (3) channel national efforts into superficial patchwork remedies, and (4) perhaps most negative of all, legitimize the class nature and assumptions of those in power.

These are sweepingly damning statements. Let us look at them more closely. To do this, we will consider some specific projects/activities for which the design and funding have, to a significant degree, come from two broad groups of international

agencies. This involves somewhat lengthy programme descriptions. Yet the detail is necessary, in part, because of the seriousness of the criticism, and as well, because of the dearth of such analysis of health-related agencies in the past.

i. Voluntary Agencies

The complexity and sophistication of most development projects funded by international voluntary agencies has increased over the past two decades. Yet the theory behind such projects too often remains essentially unchanged — and analysis of *why* primary needs such as employment, food, literacy and health care, are unavailable to the “needy” is generally lacking. In the past, health and nutrition schemes have often taken the form of charity handouts. The classic example is the distribution of skim milk powder to slum children “at risk”. While failing to effect a significant improvement in the nutrition status of “target groups”, such schemes have tended to re-inforce the sense of helplessness of the poor. This effect is often noticeable on entering villages or slum areas where such projects have been operating. The expectation that outsiders can be induced to distribute charity is vividly established, thus making efforts to generate activities based on community organizing and a questioning by the poor of the source of their predicament considerably more difficult. Variations of these programmes have recently included selective handouts to poor women who accept sterilization. Fantastic as it may seem, the legitimacy (and indeed, morality) of such incentives for “Family Planning” remains essentially unquestioned in India, although in other Third World countries objection has been clear and pronounced.¹¹

To date there are few studies which show significant long-term nutritional improvements when such food handouts are given,¹² and many which demonstrate precisely the opposite.¹³ Project organizers are forced to awkwardly side-step the failures by alluding to possible “spin-off” effects — for example, that women come to clinics more often! As if numbers of clinic visits could substitute for lack of measureable improvement in health status, or more fundamentally, for social changes that would make it possible for the women to feed their own children.

Leaving aside the “dole out” projects, the past decade has seen a mushrooming of “package” programmes intended to “deliver” various health services to rural communities. The very term, health care “delivery” reveals the dependency-creating framework that dominates many of the schemes — a framework characteristic of the

Western medical model which interprets health as a consumer commodity (the object being to unload health “packages” into a community). Lack of consumer (ie. villager) receptiveness and the recent recognition of the success of primary health care in socialist countries (most notably in China) have led agency planners in India to promote “community participation” and the recruiting of “local agents” in hopes of smoothing over the delivery process. Few projects have however been successful enough to persuade their organizers to measure changes in health status directly, in terms of changes in infant and childhood mortality rates.

But even aside from their technical limits, what impact have recent health care projects had on the societal problem of ill-health? In pursuing an analysis of voluntary health projects from this broader perspective, a deeper understanding of the forces leading to social change is sought, even at the risk of doing a disservice to the locally-useful efforts of the innovative health programmes in the country. In the following pages we will explore the theoretical meaning of the “model” projects and look at one medically-successful programme in terms of its influence on national health policy. This section is included in the discussion of voluntary agencies because they today see their relevance chiefly in terms of creating “models” for development.

The enthusiasm for alternative health models reflects the poignant discomfort of many in realizing how much of the population yet live and labour with most of their primary health needs unmet. But within this search for new health care models, what have the experiments actually been attempting to prove? That primary health care to the poor and rural communities is indeed possible? That children do not need to die needlessly?!...

It is true that a local health project can provide improved health services for particular village families; yet the relationship in which those services are provided is still one of dependency. The villagers are just as dependent on the presence of the model project as they are on occasional handouts from the government. When the original organizers leave (whenever that may be), their programme will depend upon the good graces, personalities and whims of those who replace them. The question of the likelihood of future organizers being as sincere and committed is irrelevant. The fact is that the villagers’ relationship within society has not changed, though their health may be somewhat improved. Indeed, it can be argued that an additional source of dependency is created simply by the presence of the substitute services.

In the broader perspective then, the ultimate meaning of any alternative health programme can only lie in its potential to *transform the relationship of dependency* between the collective labouring villager and his or her society, in a way which makes the benevolence and charity of a voluntary project no longer necessary. And a project would become unnecessary only when rural communities are organized to demand adequate health care services from society themselves. The degree to which the model project contributes to enabling the rural poor to achieve justice from the social order must surely be the prime criterion by which 'health alternatives' should be judged.

Furthermore, the few successful rural health projects have also shown that in dealing with the problem of mass undernutrition, inputs of food are equally essential. This is important to recognize, for it means that, given the existing (and indeed, deteriorating) economic conditions for the rural poor, no matter how good and effective, health activities in isolation cannot offset the prime determinant of ill-health which is lack of minimally adequate food. Inputs "from above" including nutrition and child care, then, substitute for even minimally adequate wages and conditions of work for the labouring poor — that is, *substitute for economic justice*.

This leads to an interesting theoretical question: Is the meaning of the health care project to provide health care *services*, or to improve health *status*? If the primary purpose is better health *status*, then action other than health care services may be more appropriate. For example, a single successful wage struggle might have more effect on improving child mortality (in terms of food for stomachs, rupees for bus tickets to health centres, and at least relative freedom to leave aside field work to attend to the needs of a sick child) than a host of health schemes. An interesting observation from an evaluation of a rural development project in Bangladesh indirectly points to this reality. The study observed, "A quick analysis of the economics (of project activities) suggests that one successful wage struggle can do for the members' standard of living what five years of projects might do."¹⁴ This is not to imply that vaccines and the teaching of oral rehydration methods to village women should be denied to village families. But rather that the full value of particular medical techniques in terms of contributing to improved health status can only be realized within a much broader and firmly established economic and political frame of action.

Thus it is rather astounding to consider how technical solutions for health have come to dominate development thinking when, from our

common sense, from all data which are available, including the GOI infant mortality study, and from all historical experiences (including the few socialist countries of the Third World) we know that health, on the contrary, is primarily determined by efforts towards distributive socio-economic justice.

In this regard, the conclusions of a recent study of voluntary health projects in Bangladesh are hardly surprising.¹⁵ Briscoe points out that "while lip service is paid to the fashionable notions of community-based programmes, most (of the projects surveyed) offer people no responsibility and no opportunity to make decisions, only gestures and attitudes which encourage passivity". For the author, the "critical question" is clear: projects must be assessed according to their impact on socio-economic inequalities. He concludes that "the foreign voluntary agencies in the health sector... both as executors and funders, have encouraged dependence rather than self-reliance and have therefore contributed to the underdevelopment of health".¹⁶

Acknowledging then, the economic and political basis of the problem, is there any other meaning to the "model" health care project?

The very concept of model (in its original meaning at least) reflects the relationship of a group of people's specific local activities to a broader, society-large framework. The model is being developed for some broader purpose. Its meaning lies *primarily* beyond the particular activities of the local effort. This approach recognizes that it is no longer sufficient for individuals to be "doing their own thing" in a corner; that the problem of, in this case, ill-health cannot be solved by individuals "doing good" by themselves, no matter what their sincerity and intentions; that their efforts must contribute in some definable way to a *process* of change which has relevance for the country as a whole.

It might be argued by some that the very existence of a good health project has value in the broader context simply by being an example. But again, one must ask, "An example for what?" For other groups beginning their own project? This occasional outcome hardly seems relevant to the issue of ill-health *nationally*. I do not think anyone deeply involved with development issues would genuinely believe that India's social or health problems could be solved by an enormous number of voluntary groups eventually sprouting up in each of the country's six lakh villages. If that were the case, then the larger Gandhian movement should have had at least some discernable effect on national poverty and ill-health by now.

The solution then cannot be a mushrooming of "models" no matter how much one might like it to be so. At the same time, more enlightened individuals suggest that the value of model projects lies in using their successful elements to influence and change attitudes and policy at the national level. Let us consider more closely this possible broader purpose by analysing the impact of the Jamkhed Project in Maharashtra, the original of the "Village Health Worker" schemes in India.

The Jamkhed rural health project is based on relatively low cost activities which are almost completely independent of the government health care system. The programme is successful not because of any particular technical ingredients in the package of services offered, but rather because of the *relationship* between the health workers (most of whom are low caste women, often the traditional midwives), their communities, and the project organizers — a relationship of general trust and respect for the village people, particularly the poor, which allows for communication and mutual commitment to the activities. The success of the project has justifiably attracted national and international attention.¹⁷ It has also led the Central government to initiate, in 1978, a new scheme for rural health care, the Community Health Workers Scheme,¹⁸ based upon some of the technical ingredients of the original model project.

Although there has been no overall assessment of the government scheme as yet, a number of studies already reveal some major problems.¹⁹ They highlight serious difficulties in the actual functioning of the scheme (including a lack of emphasis on maternal and child care) and the absence of the essential ingredient of the "model" project — a relationship between village-level health worker and his/her community based on trust, commitment and accountability to the poorer village families. Instead, selection of the Community Health Worker (CHW) has been found to occur mainly in a hierarchical, undemocratic manner — that is, through the traditional power groups. And the relationship of the CHW with his community often appears to be curative-oriented, controlling and exploitative (charging for medicines), rather than liberating and educative.

In the government scheme, then, the relationship between those who are implementing the programme (local and administrative officials and health professionals) and those who are being implemented upon (the rural poor) remains essentially unchanged. The essential ingredient of the successful model project is left out and ignored. What is important to appreciate, however, is that this result is

quite predictable. For there is no mechanism or structure within the village communities (and between the village and the bureaucratic/political structures) to ensure an egalitarian and committed working of the scheme. In addition, since the CHW is paid and supervised from outside the village, his primary responsibility can only be to this external system. The preciousness of the guaranteed monthly stipend, *no matter how meagre*, can only result in the CHW's loyalty becoming entrenched with the external project officials rather than with his community. The CHW thus basically becomes a village-level extension of the Primary Health Centre's paramedic field-workers. If the essential relationship of a CHW approach is therefore doomed when placed within the caste-class structure of society, what possibility is there for effective broad replication of the locally successful 'model' project?

Furthermore, in considering the overall relevance of the Community Health Worker scheme to the *national* problem of ill-health, the government leaves untouched the issue of re-structuring control within the existing health system. It thus leaves the system's contradictions even more entrenched with the added legitimacy of token village participation represented by the CHW. Nor does the government scheme alter the present organization of the urban hospitals to better suit the needs of the labouring villager in search of more than aspirin care. And perhaps most fundamental of all is the question of absolute poverty and malnutrition which is the source of most "excess" deaths in rural areas. The CHW scheme does not begin to address the problem of the working mother, whose exploited daily labour precludes the possibility of adequate feeding of her young children let alone the opportunity of taking them to a hospital or clinic for curative care.

The government scheme therefore leaves unchallenged (and unacknowledged) the basic causes of ill-health — the absolute poverty of the labouring millions and the control of the health system by professionals and officials whose primary responsibility (and interests) remain above and outside the rural communities rather than to the poor and sufferers of ill-health.

Briscoe summarizes what many observers have noted in analysing "innovative" health projects which attempt to adapt the concept of the Chinese barefoot doctor to non-socialist countries: "The techniques and technology used by the Chinese are emphasized; the social and political organization which is the *sine qua non* of the Chinese health system is ignored. For it is not the barefoot doctors or

double-septic tanks which explain the success of the Chinese and Vietnamese systems, but the realization that 'as long as man is exploited by man, there cannot be a systematic fight against disease'.²⁰ In other words, the barefoot doctor approach is successful in China not because of techniques or "barefootedness" but because of the relationship between the local health worker and his/her community, and between groups throughout society — a relationship which is egalitarian and collective and which exists *because of* the transformed socio-economic and political structure.

This study of the Central government's Community Health Worker scheme has been included here to highlight the inherent limitations of the voluntary model project in terms of its replicability. If this is the case, then where does the meaning lie in even the best of voluntary health projects?

If in its activities, the voluntary project fails to confront the basic assumption and the powers in control of health resources nationally, fails in addition to challenge the primary source of ill-health which is exploitative class relations throughout society, and thus the maldistribution of *all* resources, then the national relevance of even the technically best model project must surely be in doubt. This is not to say that within voluntary projects this confronting of fundamental issues *cannot* come about. It is simply stating the obvious — that in India, as in other areas of the Third World, as Briscoe's study suggests, it rarely if ever does. Many voluntary health agencies are reluctant, for obvious reasons, to confront these deeper, political issues. Yet, in avoiding them, they tend to strengthen the impression that "something is being done." And, in this way, by default, they contribute to the legitimizing of the existing social and health systems, and thus as Briscoe suggests, to the "underdevelopment of health."

A comment in a recent *Indian Express* article aptly reflects this situation: "The role of the voluntary agencies is another crucial element in the struggle of the Scheduled Castes (and oppressed, generally). Just as the legal and political systems get manipulated by the dominant groups for their own benefits, so also the resources of the voluntary agencies can become a means to perpetuate existing imbalances of power rather than to assist peripheral groups to organize themselves... However, more and more voluntary agencies now seem to be aware that they have, through their policies and programmes, unwittingly been contributing to the perpetuation of an unjust social order...(But) the fact that most of the voluntary agencies either come from the ranks of the dominant groups or are imbued with

their values and ideology makes the eventuality of making vast resources of the voluntary agencies available to these groups in a planned and constructive way a remote possibility."²¹

A postscript is necessary. This section has primarily been an examination of the inadvertent, legitimizing effects of health projects funded by international voluntary agencies. Its aim was not to entirely reject the social validity of health action. In the third part of this analysis, the potential, though often unrealized, broader value of health action will be explored more closely.

ii. Official Agencies

If the voluntary agencies have seen their Third World role as developing primary health care "model" schemes, the role of the larger official health and health-related agencies has, in the past, been more in terms of providing technical and material assistance, particularly through the UN-related agencies such as UNICEF and WHO. *Bilateral agencies* (that is, government development agencies of particular countries, such as USAID or the Canadian International Development Agency) and *private foundations* like Rockefeller or Ford, have likewise played key roles in establishing and/or assisting centres of "medical excellence" in India.²² The All-India Institute of Medical Sciences in New Delhi — the "Johns Hopkins" of India,²³ is such an example. These agencies have also played an *advisory* role for several major government health/nutrition programmes.

It is not possible within this analysis to offer a detailed evaluation of the effects of these various agencies in India. There is no question that their technical assistance has been considerable. The WHO involvement in the Smallpox Eradication programme is one single example (even though motives of self-interest were behind much of the Western funding). Yet the question posed here is different: what has been the overall effect of these agencies in India, if one places their specific successes within the whole of their activities and influence?

Obviously, it is impossible to specifically "measure" positive versus negative effects, since two separate categories are being dealt with: technical benefits versus social, even political, effects. What is offered here, then, is simply an opinion as to the significance of their non-technical effects. To illustrate this position, it will be useful to look at several agency-assisted health programmes. The examples are chosen not to criticize *particular* mistakes or failures, but rather to raise more *theoretical* questions.

One example is the Applied Nutrition Programme (ANP), a major Central government project begun in 1960. Though shaped in large part by international advisors, the ANP has been mainly funded by the Indian government. The purpose of its activities has been the improvement of rural nutrition standards through the encouraging of village school and kitchen gardens, poultry raising, and village-level nutrition education. As well, it included feeding centres for young children. Successive groups of rural Blocks were, and continue to be, included in the project for periods of four to five years.

An unpublished evaluation of the scheme in the mid-1970's revealed major organizational problems with programme implementation, and more importantly, no demonstrable changes in nutrition standards. No Block moreover had applied to have the programme continued, though such extensions were allowed for in the scheme design.²⁴ The programme however continues unabated, absorbing enormous funds almost as if with a momentum of its own. That the momentum continues at all indicates that the ANP is indeed meeting some people's needs, but it has yet to be clearly demonstrated that they include those of the rural poor.

A series of even more "comprehensive" and costlier schemes have been implemented with the assistance of international advisors, each programme promising to be more comprehensive, more "grassroots" and more "packaged" (examples include the Multi-Purpose Worker Scheme, and various projects associated with the International Year of the Child), and each failing to produce the desired effect, that is, basic improvement in health status. The reasons are not difficult to understand. Advisors in international agencies are placed in the awkward position of being "instant experts." This is so from the very way the agencies are organized and staffed. With little opportunity for understanding the cultural let alone economic reality of the village masses, the chances are slight for the advisors to have a deep appreciation of the problems — or perhaps even to identify the correct issues. Unfortunately *this cultural and economic isolation from the rural masses is almost as deep for locally recruited "national" agency members, who themselves are urban, highly educated and therefore removed from village realities.*

But of equal significance is the fact that the plans and actions of international agencies are restricted in scope by the need to remain strictly a-political. While experts now debate the complexities of maintaining the "cold chain" for measles vaccine in the rural areas, tea stalls in most towns and larger villages are bathing Coca-cola in ice

blocks and refrigerators for consumption by the local elite. If refrigerators and ice blocks are available for such purposes, why are they not available for vaccines for the rural poor? The problem then is one of control and distribution of resources, which of course has political implications. That agency officials dare not, or perhaps care not, raise such issues only adds legitimacy to the present maldistribution of resources and power. Yet, if the issues of malnutrition and ill-health are those of gross and increasing inequalities between groups in society, the solutions must inevitably lie in the realm of political action, and not at the level of patchwork schemes, good intentions and imported expertise. The ultimate result of often highly publicized agency-assisted schemes is to increase the self-satisfaction and complacency of health professionals and government officials that "something is being done", and to strengthen the impression amongst the electorate that those in power are "doing everything possible".

Another damaging effect is the tendency for mystification of programme evaluation. In most cases in India, international and national planners steer shy of targeting for *ultimate* objectives; that is, for changes in specific health indices such as mortality rates in young children. Instead, basic goals are confused and obscured with a mixture of "intermediate" and "organizational" objectives, such as the numbers of patients attending clinics or Vitamin A doses distributed. While these may be important indicators of the mechanical functioning of a programme, they often have little or no relation to the actual health status of the people involved. For an agency's activities and positions to be justified, however, some accounting for lack of demonstrable improvement in 'hard health data' is needed. And so it has become fashionable to talk of "spin-off" effects. Unfortunately, the "spin-offs" are usually not related to ultimate health goals either!

What is worse is the nurturing of the assumption that it is difficult if not impossible to collect hard health data such as rural childhood deaths, therefore making direct evaluation impossible. This mystification is convenient for it absolves the agency of ultimate accountability. A paper on evaluation methods by a major international agency goes as far as to conclude that "evaluation of objectives in health services administration, Maternal and Child Health specifically, is difficult because it requires controlled studies, trained personnel, often-times special facilities. It cannot be expected that evaluation of this type will be a part of many projects."²⁵

In challenge to this view, it should be stated that measuring

childhood deaths in village communities is not only possible but relatively straight-forward if the communities are directly involved and therefore understand the health activities, and if the workers and evaluators are sitting in the villages rather than in an urban office. The mystification of an event as dramatic as a child's death in a community is indeed a reflection of an agency's remoteness. Clearly, this is evading societal accountability. In this sense, international development agencies are in the remarkably artificial position of being entirely unaccountable towards those who become their "beneficiaries." There is literally no recourse if programmes fail, or worse, add greater legitimacy to existing power structures — a problem inherent in the very nature of development aid.

But perhaps the most damaging effect of the large international agencies is their direct role in legitimizing the class nature of the medical profession. As part of an elite in his own country, the international health consultant arrives in a Third World country and joins his professional counterpart as an elite among elites. His unquestioned position of authority is the envy and aspiration of his local colleagues. And though he may talk of rural problems or perhaps even visit some villages during his assignment, (returning immediately to his hotel or residential enclave), in the eyes of the national professionals he very much remains a member of the special elite.

Confronting the obvious maldistribution of health resources in the course of their work, schemes for addressing rural ill-health take the form of "Pilot Projects" often tacked on to the urban medical colleges. Such projects are as a rule only short distances from the parent institution so as to be convenient to supervise, and thus bear little resemblance to the average truly rural setting. That pilot health projects are often designed to be convenient for the planners and advisors is only one example among many that re-inforces the professional's position not only in health planning, but as well in society generally. The message is clear: the priorities of the professionals come before those of the rural poor. Unconscious as this re-inforcing may be for most of the consultants, the effects are just as powerful.

Let us now look closely at a recent example of an internationally-inspired and assisted health scheme: the WHO/UNICEF spearheaded "International Year of the Child" (IYC). It seems important to relate what this enormous programme meant from the viewpoint of an Indian villager. And to analyse, within a broader theoretical perspective, the underlying ideological framework and assumptions which the scheme has reinforced.

At the local level, the IYC (1979) was marked by grand gatherings of health, government and agency officials extolling the "importance of the nation's children for the nation's tomorrow". The concern in the speeches was emphasized by the distribution of sweets and balloons to the small groups of children collected for the inauguration ceremonies. Walls of public hospitals were adorned with glossy posters bearing the IYC symbol and photos of wide-eyed needy children. The resources and manpower of the country were to be mobilized to reduce infant mortality by 5%.²⁶ Part of this improvement was to be realized through increased efforts in the country's immunization programme; and at the community level, through a unique set of activities termed the "Child-to-Child" scheme. Skillfully organized and set out in handsome work manuals, the aim of this special programme was to improve the care of young children by bettering the skills of their older siblings — in sensitive recognition that in most Third World countries young children of poor labouring families are cared for mainly by their only slightly older sisters and brothers. The approach was undeniably innovative. In a massive way, as with the ANP of the previous decade, information was to be disseminated on nutrition and simple health care methods, such as the prevention of dehydration by oral rehydration at the mud hut level. The programme appeared to assume then that the main cause of high childhood mortality was insufficient health information on the part of the poor. Its proposed activities were an attempt to fill this gap.

Several years later it is yet very difficult to find any assessment of the campaign. One suspects that the logistics of identifying, gathering and educating the "mother-substitutes" would be difficult, especially through the proposed medium of the village school system. Difficult, because these families whose child care lies primarily in the hands of older children, are precisely those which are too poor to send their children to school, or even to child care training sessions. However, the problem of logistics apart, the general strategy and assumptions of the scheme beg for broader analysis.

In essence, the Child-to-Child scheme is an extension of the "self-help" health care concept. Since all previous approaches (such as increasing numbers of rural health centres, nutrition programmes, armies of health auxiliaries, integrated maternal and child packages) have failed to transform the picture of rural ill-health, the IYC organizers chose to focus on the capacity of villagers to provide their own primary health care. Yet in effect, the underlying assumptions of the scheme also tacitly place ultimate responsibility for health upon the

poor themselves — indeed, upon their children.* What are the implications of such an approach?

There can hardly be any objection to the goal of providing practical health information to the rural families. But could this information ever begin to offset the effects of inadequate food (including breastmilk to young infants of labouring women)? Or could it ever take the place of adequate, just wages? Furthermore, it is important to distinguish between responsibility and power. While the Child-to-Child scheme clearly shifts responsibility for primary care onto the poor, there is no similar shift of power or control over health resources to these same poor — nor of economic powers. Neither can the poor insist that government health workers be available in their villages at times which would make their services accessible to them; nor can they hope to change the organization of the urban hospitals so as to allow them to make better use of the facilities there. Responsibility without corresponding input into the functioning of the existing health system can indeed be worse than an empty gift.

Moreover, no questions are asked as to what then is the relevance of the existing health system, or that of substantial amounts of public resources involved in the training of so many doctors each year. How do they fit into the schemes for child health? What exactly is *their* responsibility for the health care of the country's children?... The unstated, and presumably unconsidered, effect of the programme is the absolving of the profession, the health system and the socio-economic organization of any *primary* responsibility for rural health. And that is convenient. The activities pre-occupy, so that the government and the medical profession need not ask the basic social question: who continues to benefit from the national health resources, and who does not, and why? Qadeer therefore rightly asks: "Is it, then, that the slogan of people's participation is more for convenience of the elite, since it gives them the advantage of shifting responsibilities from their shoulders to that of the people?"²⁷

The self-satisfaction generated during the IYC adds legitimacy to the profession, while leaving unchallenged the contradictions within the health system. This result probably outweighs any positive local effect of the scheme. How is such a judgement justified? Simply by remembering what the real roots of childhood malnutrition and

* This is an interesting point of arrival for liberal development thinking, for in effect it represents an acceptance of an even more regressive form of social organization in which the social costs of reproduction of labour are borne increasingly by the labouring class — and in this case by their children.

mortality are. They are *not* primarily problems of health technology, nor even of information flow. They are problems of destituting poverty that preclude adequate child care and feeding, and also prevent village families from making effective use of the health system. They are problems of inaccessibility of these services. And finally, they are problems of powerlessness of the poor to confront inadequacies and injustices within and without the health system.

Between four and five million children die unnecessarily every year in India. Can a Child-to-Child scheme have any meaningful impact on that reality based within the existing socio-economic and health system? If not, what must the honest approach be? If concern for the nation's children is genuine, is there not an obligation to think of the five million and not simply of the fortunate few who might be reached by the filtering down of a scheme through the entanglements of a health and social system that is geared to the needs and priorities of a social class which includes almost none of those five million?... Not surprisingly, such fundamental issues are avoided by the advisors.

As the story of Rakku's struggle reflects, high childhood mortality and malnutrition in India is primarily a *social* problem, not a *technical* one. And therefore it ultimately requires socio-political solutions for which the international health and health-related agencies are least suited and least willing to be involved. Unfortunately, the very presence of the agencies, whether official or voluntary, tends to add to the de-fusing belief that problems of underdevelopment, including ill-health, are technically solvable.

This lengthy consideration of international health aid is an attempt at understanding one of the ways in which the existing health system is legitimized. Yet the theoretical framework underlying the activities of such agencies simply reflects prevailing notions of how "development", including health development, can take place. Thus, to confront the inherent limits and negative effects of such aid, one needs to examine critically the tenets, assumptions and contradictions contained within liberal development theory as a whole.

3. Liberal Development Theory

Liberal development theory, in its basic welfare approach to societal problems, is inadequate for several reasons. It fails to analyse the source of underdevelopment, and thus also fails to inform action capable of transforming the social structures and relations which perpetuate poverty. This section will first of all explore these limits by highlighting some of the contradictions and underlying motives

contained in liberal development approaches in the country. It will then analyse more deeply the "provision of basic needs" concept and the nature of "underdevelopment." It will end by a critique of the "health for all" strategy.

i. Contradictions within the model

An understanding of the fundamental reasons why children and adults are unhealthy and die unnecessarily makes possible a clearer assessment of schemes to "provide basic needs" and of model projects for "alternative health care". Current liberal development thinking assumes that "development" can occur through the channeling of inputs, whether technical, informational or material, into rural communities either by government structures or voluntary and international agencies. The failure of this strategy over the past two decades has recently led to a greater emphasis on "community participation" in the channeling process. But as we have seen, these programmes, whether it be an Applied Nutrition Programme, an Integrated Child Development Scheme, or a Community Health Worker programme, most often remain organized, implemented and controlled primarily from *outside* the rural communities. Indeed, "the talk of people's participation in health care services is loudest — without actual participation — in countries where the mass of the population lives in a perpetual state of oppression and deprivation."²⁸

The point is that the reality of conflicting interests within most rural "communities means that such theorized community participation can only be token — and the notion of common interests and potential harmony, tragically unrealistic. Most villages are sharply divided between the few who own and control resources (particularly land, but capital and technology as well) and those whose labour and lives are controlled by this owning minority. Society is thus divided into groups or classes whose fundamental interests are, by definition, conflicting. This is, of course, one of the main reasons why government agencies intuitively feel that they must retain external control of their activities — though recognition of this basic contradiction is usually avoided. Unfortunately, this control, rationalized as "inevitable", only serves to re-inforce the pattern of dependency of the poor.

In truth, within the existing socio-economic order, there can be little genuine participation by the "people" because there is no one "people". As one observer remarked, such thinking "assume(s) that there is some straightforward simple entity identified as pertaining to the common good, which can always be stripped naked by discussion and

acclaimed by all. I would argue that there can only be common interests in egalitarian communities which Indian villages are not. It seems to me that such stifling of the conflict of interests and opinions, serves not the emergence of synthesis from thesis and antithesis, but the interests of powerful individuals and groups. The consensus which emerges is always the view of the rulers, not of the ruled."²⁹

The introduction of "basic needs" schemes into deeply divided communities most often serves to act "as an anaesthetic, distracting the oppressed from the true causes of their problems and from the concrete solution to these problems. They splinter the oppressed groups of individuals hoping to get a few more benefits for themselves."³⁰ Freire termed such white-washing social welfare activities by those in power as "false generosity", an "attempt not only to preserve an unjust... order, but to 'buy' peace (of mind)."³¹ Thus, in order to have the continued opportunity to express their "generosity", the ruling class must perpetuate injustice as well. Qadeer likewise observes that within "the semi-feudal nature of social relations in most Indian villages, 'Giving for the poor'... earns for the richer sections, the right to exploit the poor and strengthens their own social dominance."³²

Development projects and model schemes, then, are irrelevant to the ultimate problem of ill-health, no matter what their technical innovation and expertise, unless they clearly lead to empowering the poor and health-less to confront their dependency not only with regard to the existing health system, but more importantly within the entire social order; unless they lead to confronting the reality of the present gross maldistribution of health and economic resources, and the powers that continue to legitimate and tolerate such injustices. Development efforts which do not *start* at this basic level of analysis and action are irrelevant to the national struggle for health. Even worse, they contribute to the obscuring of the central issue, that is, the question of *why* this maldistribution exists in the first place.

Development Work Motives

This brings us to consider the motives behind development activities. First, it may be useful to look at voluntary projects. While voluntary health programmes have generally been motivated by good intentions, it is frequently possible to trace other motives as well — some of which were openly acknowledged, according to the established thinking of the times. Thus charity was often used for something, an ulterior purpose which was judged in the best interests of the poor — "for their own good". Charity fostered a kind of dependency which prepared the ground for accepting the other goals of project organizers.

In the past the ulterior purpose was not uncommonly religious conversion. More recently it has become common and tacitly accepted to use health projects to popularize Family Planning. Even to this day official support for voluntary projects is often conditional upon results in this field. One of the most blatant examples of such manipulation is the distribution of (CARE) food shortly after childbirth to poor women who accept permanent sterilization. It is evident that the ultimate goal of this "development" effort may not be in the longterm interests of individual women and families, making the food handouts a stark manipulation of human hunger. This is not to suggest that women should not be provided with methods of fertility control, an important issue of women's rights. But clearly this is a very separate question.

One can interpret in a similar way the recent increase of interest in child health care by Western development agencies — for, in the light of two decades of resistance to population control campaigns, it is now believed that reducing infant mortality would lead to greater Family Planning acceptance.

Even the *personal need* to "do something", to see immediate results for one's efforts, becomes an "ulterior" motive which can directly shape development activities. In order to produce tangible results, projects are channeled away from the structural issues which are "messy" and difficult to confront. Project organizers come to inject their own reference terms for action, as well as material inputs, so that the deeper socio-economic and political issues may be side-stepped. The seemingly innocent personal "need" thus becomes as distorting and dependency-creating as the ulterior motives previously described. This is, of course, an *inherent* conflict for international voluntary agencies which have to "show results" to the donors "back home".

These few examples point to the need for re-examining the entire phenomenon of development aid in a more critical light. Within the last several decades development agencies and projects have mushroomed into an enormous and booming business — indeed, an industry! Development has in many ways become a vested interest for the hundreds of thousands of individuals thereby employed, and for the groups and powers, national and international, which fund such agencies. Underdevelopment, like ill-health, has become commodified. A critical analysis suggests that one of the main purposes of Third World aid programmes is to support "the ever burgeoning international development establishment". Martin therefore writes: "Underdevelopment has been and continues to be a

growth industry. Huge bureaucracies, both national and international, exist with the ostensible aim of bringing about development. Conferences and journals turn out a never-ending stream of new phrases and catchwords, and strategies for ending underdevelopment. While the reality of underdevelopment has, if anything, worsened since 1960, the number of people whose incomes depend directly upon it has grown markedly."³³

Agency needs which lie behind the outward functioning of projects thus tend to become potent ulterior motives shaping even the best of development programmes. Individuals within development agencies are employed to find or develop projects for the agencies to fund. Their jobs depend on their capacity to dispense funding allocations. Projects risk being valued on the basis of their capacity to spend agency funds rather than because they contribute to lessening the dependency relationship of the poor within their societies.³⁴ Thus, by their very nature, development aid activities come to reflect very different "needs" from those of "helping the poor".

More ominous motives than personal or agency needs however shape international aid programmes. Since the beginning days of "development assistance", aid-giving has clearly been used to bolster particular Third World governments ideologically sympathetic to Western political and economic interests. Because of the vastness of the subject, the political economy of foreign aid is considered in more detail in Appendix III. Here it is enough to examine one central concept of liberal development theory in order to reveal both its inadequacy as a poverty-transforming theory, and its underlying ideological interests.

ii. A Critique of "Provision of Basic Needs"

If ill-health and poverty are issues of dependency and unjust social structures, how then should the development strategy of "provision of basic needs", including health, be judged? The very term "providing" betrays the paternalistic and therefore controlling framework of such development thinking. It speaks of efforts which tacitly accept the existing power relations within society; and in doing so, add to the dependency and powerlessness of the poor. In the ultimate analysis, the thrust of this approach can be interpreted as an attempt to stave off a fundamental reorganization of society which would eliminate that dependency — a new social order which would make the "false generosity" of a dominant class unnecessary.

Furthermore, the notion that "basic needs" for hundreds of

millions can be externally provided from above is as unrealistic as it is ulteriorly motivated. Unrealistic, if the society remains so structured as to perpetuate not only vast unproductivity through unemployment and underemployment, but as well the existing distortions in the use of national resources and skills by their being channeled into luxury concerns and items intended only for the small elite. The health field is only a single example of such a distortion. This national waste and unproductivity cannot be conveniently "made up" by distributing "basic needs" to those left out by the system, no matter how much the World Bank, for its own reasons, would like it to be so.

Moreover, the very idea of providing basic needs to the poor majority is a deeply reality-distorting suggestion. For in fact it is the labouring majority who grow the nation's food, construct the houses, build the roads and canals, and weave the cotton. In the process they are, within the present socio-economic order, forced to sell their labour at dramatically exploitative rates. For example, in agriculture which is the single most important sector of the economy, those who directly till the soil must often give away half to three-quarters of the produce of their labour to those who contribute little or nothing — the "owners" of the land. It is clearly, then, the poor majority who are already "providing basic needs" to the country (and to the international economic system as well). The suggestion that the ruling class should gratuitously "give" basic needs to the poor is nothing short of obscene. For in essence, those basic needs do not belong to the ruling class "benefactors" in the first place. Again, the international development jargon obscures the existing societal contradictions, and conveniently also the source of the problem.

The link, then, between Rakku's poverty and her personal struggle to save her child extends beyond the landowner's lush green fields. Beyond too the crowded urban hospitals and even the social structures of Indian society. The issues of ill-health also encompass the fundamental assumptions of the health, socio-economic and political systems which the elite in India have adopted from the West — *assumptions and structures which remain bolstered and legitimized by the development agencies from these same countries.*

iii. The Concept of "Underdevelopment"

While it is important to appreciate the dependency-creating framework of the "provision of basic needs" strategy, and to trace the ideological source of such development thinking, it is still more important to understand WHY such theories are inadequate to solving the economic problems, and the resulting ill-health, facing the

country. In the previous chapters we have encountered a number of concepts, such as exploitation, dependency and marginality. These terms refer to critical factors determining Rakku's predicament, and therefore require a more precise understanding. For example, we have talked about Rakku's poverty as being a result of the exploitation of her labour. But this, while true, is an incomplete explanation. For Rakku is poor not only because her labour is exploited, *but in addition, because of the very low level of economic productivity in the country within which she labours.* This low level of productive forces is what is generally meant by "underdevelopment". To understand how the two problems of Rakku's individual exploitation and this societal poverty are related, one must look at the specific nature of capitalism in India. That is, one must investigate the characteristics of "backward capitalism".

The following pages do not pretend to be an economic treatise. Clearly, the reasons for underdevelopment are broad and complex, involving economic and political forces both within and external to India. For example, the historical and persisting relationship of the national economy within the international economic order plays a primary role in perpetuating underdevelopment — the development of national productive forces being continuously hampered and distorted by relations of unequal exchange between the developed and underdeveloped countries generally. However, in these pages we will focus on one aspect of the economic forces *within* India which also contributes to underdevelopment. Specifically, we will look at the interrelationship between Rakku's exploitation and the underdevelopment of productive forces generally in the economy. This one aspect is presented to further illustrate the superficiality and inadequacy of "provision of basic needs" as a strategy for interrupting the poverty cycle.

But how appropriate is it within a health analysis to be looking at what are basically economic questions? This section is included precisely because the action of health workers is already being shaped by underlying economic assumptions, specifically, liberal development theory. This being the case, it becomes essential for the health worker to have some basic understanding of underdevelopment as a historical process.

The Source of Dependency

India's economy is, in spite of some major public services and infra-structural state enterprises, a market economy. Ownership of the means of production is primarily private or individual. And as in every

such economy, labour power is also a market commodity, to be bought and sold. This is increasingly true for the agricultural sector as well, as more and more of the rural labouring population is turned off the land and survives not on the basis of traditional (feudal/serf) reciprocal obligations with landowners, but on the basis of *daily wage labour*. This process is a function of the spread of commodity production in agriculture; that is, production for a market rather than for immediate local consumption. It is this economic structure which ultimately defines Rakku's poverty, her marginality, and her dependency — although, as in every society, religious and/or social theories are used to inhibit the understanding of economic processes.

Within such a labour market, what determines that wages are so low? And the acceptance of such wages? First, the market laws themselves, which assign wage rates not according to the real value of what the labourer produces ("real" in the sense of the amount of labour embodied in the product), but through the process of *competition* for such employment among the vast and increasing numbers of un- and under-employed. As a result, the labouring majority find themselves in competition with each other, forced to accept the lowest wage which allows them to survive. It is this desperate competition which divides the labouring poor from one another, and compels them as individuals to hang helplessly onto an employer or patron at whatever wage is offered. This is the essence of present-day dependency — the clinging and scrambling for employment "handouts", for the momentary security of a ragi-filled cooking pot obtained by a daily wage. It is this dependency which makes possible the exploitation of their labour — "exploitation" meaning the difference between the value of the wage the worker is paid and the value of the product his labour has produced for that wage.

At the same time, however, the "parasitic" exploitation of individuals such as Rakku is *in itself* a major factor preventing the development of productive forces in the country. Let us look at this more closely.

Why Low Productivity?

In India, the agriculture sector forms the base of the economy, generating 43% of the national income and employing almost 70% of the workforce.³⁵ It is thus considered the key sector for increasing production in the country. The possibilities are enormous. Yet, in spite of almost two decades of "Green Revolution" techniques, average crop yields remain low.³⁶ What then are the obstacles to increasing agricultural production?

One of the main barriers to the development of the agriculture potential are the particular *relations of production* which exist in the rural areas (and in much of the urban unorganized sector as well). By "relations of production" is meant the nature of the relationship of power and control between the various groups or classes involved in agricultural production.

It is the larger landowners who have surplus, marketable grain beyond their own consumption needs. Much of this surplus is not however re-invested to increase the general level of production, but rather diverted into personal luxury purchases — that is, into unproductive consumption such as gold, dowry, wedding celebrations, cars or perhaps capitation fees to get a son or daughter into medical college! If the landowning class is, for example, interested in improving irrigation, they naturally invest in private wells/pumpsets and not in public, organized schemes which would increase the overall efficiency and productivity of an area. On the other hand, small peasants who own only subsistence plots of land are often unable to invest at all.

There are several reasons for generally low investment in agriculture. These include the relatively high costs of inputs due to the import of raw materials and technology for such things as pesticides and fertilizers. As well, government policy has consistently resulted in a selective channeling of inputs and loans to the larger landowners and to specific rural "pockets" where the potential for growth is high. But it is also true that many larger landowners are not greatly interested in extensive technological development simply *because they do not need to be*. Already they earn "comfortable" profits by extracting surplus value from those who labour for them. These profits do not generally come from extensive use of technology (that is, from improved forces of production, as in advanced capitalism), but rather from maximum exploitation of those who directly till the land and produce the wealth.³⁷ Since agricultural labourers are mostly unorganized, and therefore unable to exert pressure for higher wages, they are entirely vulnerable to this exploitation. But besides leaving the landless in a desperate state of impoverishment, this lack of organization also means that the landowning class as a whole is not *pushed from below* to take the risks of large-scale investment — a situation in sharp contrast to advanced capitalist production where a farmer *must* be highly productive (that is, must use massive technological inputs) to survive within the competitive market. The absence of sheer necessity for major re-investment, due to the

continuing opportunity to extract surplus value from labourers, is what distinguishes capitalist agriculture in India as "backward."

This backward character of agriculture moreover *directly contributes to stagnation in the industrial sector of the economy as well*. The increasing impoverishment of the rural masses eliminates much of the "demand" for industrial products because the majority of the population are simply too poor to buy consumer goods. This is evident from the fact that a very large proportion of the people, those living under the poverty line, spend so much of their total income (more than 80%) simply on food, and the most basic cereals at that. As a result, industrial production becomes increasingly channeled, by virtue of the market forces, into luxury articles (cars, scooters, electric food grinders, etc.) for the small elite class which has substantial purchasing power, and not into goods for the masses of the people. The labouring majority are in fact left more and more out of reach of these commodities. Capitalism in India has thus produced a widening gap between the rich and the poor — and in addition, a *stagnation* in productivity generally because there is a limit to what even the elite minority can consume.³⁸ So the exploitative relations of production in agriculture come to thwart growth and development of the productive forces both in agriculture and in industry.

But what is the source of this extreme exploitation? How is it that it exists? And that it continues to exist?... The highly skewed distribution of land means that much of the work on the larger holdings is done by people who do not own the land, that is by tenants or agricultural labourers. The economic *power* possessed by those who own land, and conversely the economic *powerlessness* of the many who do not, determine, as we have seen, the incapacity of unorganized labourers to press for a larger share of the produce. But how is it that such a *degree* of exploitation is, one might say, "socially acceptable" — that it is seen and accepted both by landowner and labourer as legitimate?

Any economic system reflects specific social values. One of these values in Indian society includes an extremely exploitative relationship between different social groups (classes/castes). India is hardly unique in this respect, for most societies accept varying degrees and forms of labour exploitation. There is indeed a consciousness that the highly exploitative relationship between landlord and those who work his land, is just, legitimate and "natural." And this is so because the traditional concept of relationship between groups in society is hierarchical and devaluing of physical labour. Labour is not rewarded on the basis of its value to society, but rather on the basis of traditional

notions of inferiority and impurity. In India, the religious sanctioning of exploitative labour relations has become particularly formalized and openly justified by the notion of caste. This traditional valuation of labour on the basis of hierarchical-cultural values rather than economic value, legitimizes the maximum extraction of agricultural production from the direct producers.

Such a belief system, or ideology, then, is one of the major factors lying at the heart of the poverty-underdevelopment cycle. This, in contrast to, say, population pressure which is a real though superficial *symptom* of underlying economic contradictions in society. As Djurfeldt and Lindberg conclude from their health analysis of a rural area of Tamil Nadu: "If the productive forces of Thaiyur agriculture were fully developed the village could easily accommodate twice its population... Over-population... is only a *relative* over-population: people do not starve because there are too many to share too small a cake. They starve because they are exploited and denied a just share of the cake... And it is largely as a consequence of this exploitation that the cake is not growing. The current agrarian structure thwarts rather than promotes the growth of the productive forces."³⁹

Exploitative socio-economic relations between classes, then, is not only at the heart of Rakku's poverty and her family's ill-health; it is also a central factor in national poverty or underdevelopment. Clearly, there are other key factors contributing to economic underdevelopment, particularly the relation of dependency of the national economy within the international economic order. But for the purpose of understanding Rakku's predicament within her society, the role of exploitation *within* India itself is also important.⁴⁰

We have studied two key issues in this section. The first is the additional role which exploitation plays in Rakku's poverty; that is, its role in maintaining low productivity generally in society. The second is the role of social and cultural values (ideology) in this exploitation. Within this deeper perspective regarding the source of poverty, the liberal development concepts of "provision of basic needs" can be seen as woefully simplistic (as well as convenient for the national and international ruling classes). For neither does such thinking even hint at the source of the problem, nor therefore can it provide a realistic solution. The above "digression" into purely socio-economic issues may at first seem out of place in an analysis of ill-health. Yet it is only by understanding what makes people poor — and society as a whole poor — that it is possible to also understand what ultimately deprives them of reasonable health.

But there is one further aspect to the underdevelopment — ill-health dynamic. In chapter five, we considered how the economic order prescribes the basic unimportance of the health status of individual labourers. A clearer understanding of underdevelopment shows how this can be so. The stagnant nature of capitalism in India means that most labourers continue to require few technical skills. They thus require minimal training and little or no formal education. Replacement of unhealthy workers therefore costs nothing — is of no financial consequence in terms of retraining costs. This situation is also in sharp contrast to *advanced* capitalism which *does* require the working class to be reasonably healthy: because of the technical nature of advanced capitalist production, workers require special, albeit often routine, skills. This means that illness in individual workers — for example, those working on a car assembly line — is potentially very costly. In comparison, illness in individual labourers in India has little effect on the production process, making health status concretely irrelevant. (A further result of the need for higher education levels in advanced capitalism is a greater awareness of, and therefore pressure for, minimal health standards from the working class.)

Thus the state of underdevelopment prescribes increasing impoverishment *and* at the same time, the unimportance of continuing ill-health to the economy as a whole. In a very real sense, the present economic order contains an inherent poverty — ill-health “logic”.

iv. A Critique of “Health For All”

Within an analysis of alternative health care activities, the recent document, *Health For All: An Alternative Strategy*, jointly published by the ICMR and the ICSSR, deserves consideration. It is an important document for a number of reasons. First, it is a bold acknowledgment from government-affiliated institutions of some of the failures of the existing health system — an admission that while there have been, since Independence, some major health achievements, their “effect is unfortunately more than offset by grave failures”.⁴¹ Further, the report clearly highlights the central role of poverty in ill-health, repeatedly stressing that economic and political changes are primary in any solution to the ill-health problems facing the country. Indeed, at certain points, the report admits that such changes will ultimately require massive political organizing and action by the poor.

The report is also remarkable because it reflects some deeper appreciation of the reality of poverty. For example, in addressing the

issue of malnutrition, the authors stress that it is not possible to improve child nutrition without first increasing family income. As well, they acknowledge some of the problems faced by rural families when trying to make use of the health system. Thus they propose to establish dharmshalas or shelters at the health centres for use by villagers when bringing family members for care. At the same time, current official policies are openly questioned: “It is not enough to see that drugs are produced by Indians and in abundance”, they state. “It is even more important to see *what* drugs are produced and for *whom*.”⁴²

Policy suggestions include such political and controversial issues as “guaranteed employment” for the poor, disallowing private practice by public sector doctors, provision of creches and balwadies for the children of all working women, and making intravenous rehydration therapy available at the Sub-Centre level through the Multi-purpose Workers. These are all quite substantive proposals. What is more, to back up its commitment to a radically transformed health care system, the report recommends a dramatic increase in government health funding to a level of 6% of the GNP (from the present level of less than 2%) with two-thirds of this increase for services at the Block level or lower.

Yet there are serious weaknesses in the document, particularly in its analysis of *why* gross inadequacies in the existing health system have developed. Indeed, it is an important document in also showing how analysis of such broader issues can dissipate into often superficial, at times moralizing, and therefore “safe”, gestures. The strengths and weaknesses of the document deserve much greater attention than is possible here, but certain key aspects are especially relevant to this study.

First, while the authors honestly expose many of the inequalities in the existing health system, admitting that adequate health services are accessible to only an elite minority, they fail to pursue a rigorous analysis of why these inadequacies have “crept in”. This allows the report to slip into superficialities further on; for example, attributing the problems to inanimate structures such as large hospitals which “unfortunately” breed “impersonal callousness”, or to the training process of doctors “which alienates the student from his own people”.⁴³ Or indeed, to the “wrong prescribing habits (!) of the doctors... which has already done a great deal of damage.”⁴⁴ In other words, the report fails to clearly examine why these specific problems are predictable outcomes of not simply a foreign (Western) health system and drug industry, but also of a socio-economic system which the Indian elite have consciously adopted and from which they

benefit. This shifting of blame to particular sectors and external forces obscures the fact that it is the underlying entrepreneurial nature of medical care in India which entirely determines these attitudes and practices. And which also makes predictable the behaviour of individuals such as doctors or drug salesmen within that system.

At another point the problem is seen as one of "wrong health values" — referring to the demand for injections by illiterate villagers. "There is no escape from changing wrong value systems if the health status of our people is to be improved",⁴⁵ the authors stress, ignoring how private entrepreneurial medicine directly shapes this "brainwashing". In this way "blame" tends to be transferred away from those who control, determine and benefit from the market-shaped health system, to in fact the victims of that system. Thus, the focus of the document is allowed to shift from an analysis of the source of the problem which is a political issue, to instead the technical realm of health education and organizational planning which comprises the rest of the document. Problems which are predictable within the present structuring of powers and privileges in society and thus beg for social analysis, come to be termed "unfortunate", and can thus be dismissed. It is not surprising then that the proposals for the new alternative health strategy tend to be framed within moral exhortations ("Doctors must have empathy"⁴⁶) and wishful thinking. The authors "hope that the State level health services will welcome these changes and rise to the immense new challenges",⁴⁷ with little analysis of why, in the past, there has been little empathy and even less "rising to the challenges" — and therefore why, in the future, it is unrealistic to expect such a change.

Even more significantly, the proposed alternative model envisages the existing village Panchayat institutions as central in initiating and controlling community self-help care. While admitting that the Panchayat organizations 'are not always functioning in a healthy condition',⁴⁸ the authors again wishfully hope that such "decentralization will permit at least some, if not the major benefits of health expenditure to percolate to the people."⁴⁹ Such references to the "people" and "village community" obscure the true nature of rural society by ignoring class divisions within villages. This "non-class approach" not only "ignores the monopolization of health services by the rural rich",⁵⁰ but also allows the authors to side-step the core of why and how the benefits of rural development efforts have generally been monopolized by the rich landowning village minority.⁵¹

It thus seems simplistic to suggest that "abuse of funds at the local level

will be more evident to the people if they are well informed of the allocation and its purpose."⁵² For surely the rural poor have also been aware that funds for agricultural loans, school services, land reform, etc., are intended for them as "weaker sections." In suggesting that the poor are best suited to overcome political problems since they "have the greatest stake in the efficiency of the (health) services", the survival of the poor is ignored or forgotten: in fact, labouring families' greatest "stake" can only be in struggling for their next day's wage employment. To protest against the inappropriate use of health funds by the elite-dominated Panchayats cannot be a priority since this would immediately threaten their much more basic need — that of securing daily wages to feed their children.

One could also ask why efforts to "democratize village health care" could not even begin with the existing services, as a model for the new alternative. Why, that is, such participatory processes could not reverse the existing situation of, for example, the ANM's services being channeled to the wealthier households, as Naik and many others have pointed out: "The trained ANM attached to the Community Development Block was meant to help poor families. But she has actually become a handmaiden to the rich and the powerful rural elite."⁵³

While pointing to the need for popular and democratic control in the new health strategy, the "Health For All" document offers only a vague interpretation of how such social change can come about. Furthermore, to imply that "community" interests can be mutual is not only simplistic, but dangerous. For without the existence of a previously established base of collective consciousness and strength throughout the "weaker sections", the introduction of additional funds and authority through the existing Panchayat structure is likely to further increase the power of the elite over the poor — a result which is already evident in several of the evaluation studies of the government Community Health Worker Scheme. In her review of the current international thrust for community health workers in the Third World, Doyal concludes with the warning: "By vesting knowledge and control in those already allying themselves with existing power groups in society, these (village-level health) schemes also provide new mechanisms of social control over the peasant population, who are expected to put their own resources and labour into health schemes over which they will have no real control."⁵⁴

In steering shy then, of a substantive analysis of the social and economic forces which maintain the poverty/ill-health cycle, and at the same time, recommending yet another set of organizational/technical

policies, the "Health For All" report risks being simply an addition to current liberal development ideology. In fairness, the number of different contributors to the report may explain the varying degrees of depth in the analysis. Yet the clear policy statements which appear at various points tend to become lost amidst tangential, often superficial, issues. Not surprisingly, the concluding sections of the book fail to list many of the "hard" decisions. One is left with the impression that some of the contributors themselves have recognized the unlikelihood of the major recommendations being implemented.

'What then to conclude about "alternative health strategies"? Simply that "health strategy" cannot be the primary focus. If we seek to alter the ill-health picture of the country then the alternatives which must be sought are alternatives in the relationships of power between different groups (that is, classes) in society — creating alternatives to dependency and powerlessness and to the exploitation of the labour and lives of the many by the few. Only when such a transformation is in process will a more appropriate health strategy be possible — and indeed it will be shaped and insisted upon by the common man.

The purpose of this long and critical chapter has been to explore the various forces which continue to legitimate the present structuring of health services in India. Underlying these forces are particular assumptions not only about the causes of underdevelopment and ill-health as we have seen, but as well, about the social order itself. Implicitly contained within any social order are assumptions regarding the distribution of power within society; that is, assumptions as to which social groups or classes should ultimately control, shape and benefit from the political economy of the country. In the most fundamental sense, power in Indian society is represented by access to food. The way in which food is distributed reflects the social power structures. An examination of these structures of power and of the assumptions by which they are legitimized, is therefore unavoidable in a health analysis, precisely because lack of access to food is the primary determinant of ill-health in the country.

In this sense, this analysis of one segment of the social order — the health system — has been undertaken not in the belief that particular changes in the structuring of health services could in themselves eliminate ill-health. But rather, as a method to examine the nature of the social order as a whole. The final part of this book will therefore focus on the essentially political nature of ill-health, and thus the political requirements for social, and ultimately health, change.

NOTES

1. R. Dubos, *Mirage of Health*, Anchor Books, Doubleday, 1961, p. 126; emphasis added.
2. On this, see R. Dubos, *Man Adapting*, Yale University Press, New Haven, 1965, p. 365; and T. McKeown, *The Role of Medicine: Dream, Mirage or Nemesis?*, Basil Blackwell, Oxford, 1979, pp. 75-8 and 91-113.
3. Dubos observes that "life expectancy for a person having attained the age of 65 has risen at most from 12 years in 1900 to 14 or 15 years in 1963" (1965, op. cit., p. 230).
4. 1959, op. cit., pp. 30-1.
5. op. cit., pp. 28-9.
6. V. Navarro, *Class Struggle, The State and Medicine: An Historical and Contemporary Analysis of the Medical Sector in Great Britain* Martin Robertson, 1978.
7. Significantly, a community health advisor quite seriously suggested at a national seminar several years ago that the first and most useful step in transforming the country's health status would be to sell the country's graduating doctors at the international market price, and to channel these funds back into primary health care activities organized by the labouring poor themselves. Had he added massive land reform and wage re-structuring, he might have revived and embellished upon the vision of Virchow's social medicine, though he might also have forfeited the round of tittering laughter from the professional and government dignitaries seated around him.
8. *Report of the Group on Medical Education and Support Manpower: A Programme for Immediate Action*, Ministry of Health and Family Planning, GOI/ICSSR, 1975, p. 6.
9. See for example, S. George, *How the Other Half Dies*, op. cit.; F.M. Lappe, *Aid as Obstacle*, Institute for Food and Development Policy, San Francisco, 1980; and S. Weissman, *The Trojan Horse: A Radical Look at Foreign Aid*, Ramparts Press, 1975; and R. Carty, *Perpetuating Poverty: The Political Economy of Canadian Foreign Aid*, Between the Lines, Toronto, 1981.
10. "Open Letter to Friends of Third World", *HOW*, Jan 1981.
11. B. Mass, *Population Target*, Women's Press, Toronto, 1976.
12. One exception to this is the Integrated Child Development Programme (ICDS), a special government programme for maternal and child health in selected rural Blocks and urban areas. Included in its intensive "package" of services is a feeding programme for pre-school children. A recent evaluation of the scheme showed improvement in nutrition state of the surveyed children — a reduction of severe malnutrition from 22% to 11% in children followed up (in B.N. Tandon et al, "Integrated Child Development Service in India", *Ind. J. Med. Res.*, 73, March 1981, pp. 385-94). However, the programme as a whole raises many questions. Because of the massive inputs — Goel reports annual recurring expenditure of Rs. 3,84,300 per Block, which is well over the entire PHC recurring budget — it is unlikely such a programme can be extended in any significant way to the rest of the country. On this, see S.L. Goel, *Health Care Administration*, Vol. II, Sterling Publ., 1981, p. 207; C. Gopalan, "The Child in India", *Medico Friend Circle Newsletter*, Nov 1980, p. 5. As well, very special inputs from local Paediatric departments make significant expansion questionable. There are also major questions as to the functioning of the

- programme itself. On this, see S.L. Goel, op. cit., pp. 209-211, and L.A.V. Barreto, "Study of Front Line Workers in Different Projects in Rural India", thesis in Community Medicine, U. of Nagpur, 1979, pp. 141-49.
13. See for example, T. Gopaldas, *Project Poshak*, Vol I and II, 1975, Delhi: CARE India; and S. Batliwala, *Hunger and Health: An Analysis of the Nutrition Problem in India*, Foundation for Research in Community Health, Bombay. Batliwala concludes that the "majority of today's nutrition interventions, such as the various supplementary feeding programmes operated in India in the past decades, have failed to make an impact" (in "Rural Energy Scarcity and Nutrition", *EPW*, 1982, p. 332).
 14. Dasgupta, Kidd, Eastman, *A Study into the Proshika Process*, Vol I, July 1981, p. 57.
 15. J. Briscoe, "Are Voluntary Agencies Helping to Improve Health in Bangladesh?", *Inter. J. Health Services* 1980, pp. 47-69.
 16. *Ibid*, pp. 5 and 64.
 17. R. Arole, J. Arole, "A Comprehensive Rural Health Project in Jamkhed (India)", in *Health By The People*, ed. K.W. Newell, WHO, 1975.
 18. Raj Narain, *Towards a New Health Policy*, Ministry of Health and Family Welfare, GOI, New Delhi.
 19. See for example, *An Evaluation of the Community Health Workers' Scheme*, National Institute of Health and Family Welfare, New Delhi, Technical Report No. 4, 1978, H.R. Vohra, et al, *Dynamics of Selection of Community Health Workers*, National Institute of Health and Family Welfare, New Delhi, 1978, (mimeographed); S.L. Goel, op. cit., Vol. III, p. 21; and B.C. Ghoshal, V. Bhandari, *Community Health Workers Scheme: A Study*, Directorate General of Health Services, Ministry of Health and Family Welfare, New Delhi.
 20. op. cit., p. 50. India's experience with the CHW scheme is not unique. Other programmes jettisoned into countries without a socialist structure have encountered very similar problems. See for example, H. Ronaghy, S. Solter, "Is the Chinese 'Barefoot Doctor' Experience Exportable to Iran?", *The Lancet*, June 29, 1974. The authors comment: "If the barefoot doctor fervently and sincerely desires to 'serve the people', it is because of the cultural context of his commune rather than a chromosomal uniqueness on his part" (p. 1331).
 21. J. Kananakil, "Hope out of suffering", *IE*, Jan 7, 1982.
 22. As early as the 1930's, the Rockefeller Foundation was assisting seven model rural health units in various States in India. Recently, the World Bank has also been funding health-related projects, particularly in relation to Family Planning research. Its 1975 Health Sector Policy Paper explains: "The (World) Bank's work has brought it into increasingly close relations with WHO and, to a lesser extent with UNICEF. A Memorandum of Understanding was signed by WHO and the Bank in November 1973, outlining the interests of each in population questions... The Bank's activities in the field of population have led it into a much more direct concern with health than has been the case in other fields. Financing health facilities used for the delivery of family planning services... have taken up the bulk of loans and credits (in various Third World countries, including India)" (pp. 48-50).
 23. In 1943, the colonial government appointed the Secretary of the Royal Society to advise on the future of scientific research in India. Among his proposals, Prof. Hill advised "a great All-India Medical Centre... an 'Indian Johns Hopkins'... to gain the international repute which will put Indian medicine 'on the map'" (in Madan, op.

- cit., pp. 30-1).
24. The "Health for All" document reports that "on the whole, the programme has not fared well in practice. Its 'demonstration effect' has not been felt in most areas... (and) production programmes benefit the middle income groups rather than the poorest" (op. cit., pp. 49-50).
 25. W. Schmidt, "Planning and Evaluation", *J. of Trop. Ped. & Environ. Child Health*, March, 1973, p. 78.
 26. "IYC in India", Ministry of Social Welfare, GOI, New Delhi, 1980, p. 40. The target of 5% infant mortality reduction set for the IYC year was in itself ultimately unverifiable since accuracy of national data collection varies by a factor considerably larger than 5%. On this, see Appendix I.
 27. I. Qadeer, "People's Participation in Health Services", *Medico Friend Circle Bulletin*, Nov, 1977.
 28. *Ibid*.
 29. H. Gray, "The Problem", from *Rural Sociology in India*, ed. A.R. Desai, Popular Prakashan, 1978, p. 539.
 30. P. Freire, *Pedagogy of the Oppressed*, The Seabury Press, N.Y., 1970, p. 149.
 31. *Ibid*, p. 142.
 32. (1977), op. cit.
 33. R. Martin, "Who Suffers Whom?: Notes on a Canadian Policy Towards the Third World", *Canadian Forum*, April 1976, p. 18.
 34. In their study of development aid, Lappe et al recount how they repeatedly heard the World Bank referred to as a "money pusher". "Loan officers within the World Bank hold considerable power: they set target quotas for countries and judge subordinates on how well they find project outlets to fill those quotas. They often complain, we are told by Bank insiders, that there are not enough big projects." A report by Bank staff, the authors continue, "denounced management for measuring effectiveness and productivity solely by the number of dollars loaned and projects processed." They also quote from a similar assessment of USAID programmes: "No one has a chance to really stop and look at what is happening because of the constant pressure to get more funds on the bottom line for the next fiscal year" (in *Aid As Obstacle*, op. cit., p. 85).
 35. J. Maliekal, *Post-Independence Economic Policies*, Centre for Social Action, Bangalore, 1977, p. 29.
 36. *Indian Agriculture in Brief*, 16th ed., Directorate of Economics and Statistics, Ministry of Agriculture and Irrigation, 1977, pp. 272-75.
 37. In theoretical terms, extraction of *absolute* as opposed to *relative* surplus value. "Surplus value" refers to the value of the product which is taken away from the direct producers (labourers) by the owners (in this case, landowners). Without intensive technological inputs (ie. investment) which would increase productivity, the only possibility of extracting surplus value is to reduce wages (in fact, to the minimum level which allows labourers to survive in order to be available for more labour), and to extend working hours for the same wages. The surplus so extracted is termed *absolute* surplus value. In contrast, when labourers work in a setting of intensive technological inputs (large amounts of fertilizers, tractors, etc) as in advanced capitalist production, the same amount (number of hours) of labour is much more productive. The surplus value taken by the owners in this situation is

termed *relative* surplus value, and exists by virtue of the technological inputs. It is the continuing predominance of absolute surplus value extraction which is the central feature of backward capitalism.

38. For example, in 1960, India ranked 12th among the major industrial world powers, but by 1978 it had dropped to 23rd (cf. N. Shaw, "30 Years of the Indian Economy", *The Illustrated Weekly of India*, March 1, 1981, p. 10). Within this overall stagnation, however, lie increasing disparities between classes. This is clear from the decreasing per capita availability of pulses and cotton cloth, both of which are commodities geared to the poorer classes. Between 1961 and 1974, the per capita availability of pulses decreased from 62 gm per day to 39.9 gm. During the same period, "the production of coarse and lower medium varieties of cotton (that is, cloth used by the poor) fell by as much as 27%, whereas that of fine and superfine varieties went up by 34%". On this, see D. Barreto, *op. cit.*, p. 21.
39. *op. cit.*, *Pills...*, p. 203; our emphasis.
40. L.F. Fleri documents a similar situation for agricultural production in Bangladesh. He concludes: "Hunger, famine and misery are not natural features of Bangladesh, despite what the mass media tend to claim... If the potential of the agriculture sector is not fully exploited it is because structural and historical forces hamper its development possibilities. These obstacles are also at the origins of the limits imposed on the population and prevent the full expression of its productive and creative potential which is an essential prerequisite to improved health." (in *Issues in Health and Nutrition in Rural Bangladesh*, United Nations Asian & Pacific Development Institute, January 1980, p. 2).
41. *Health for All: An Alternative Strategy*, Report of a Study Group set up jointly by the Indian Council of Social Science Research and the Indian Council of Medical Research, Indian Institute of Education, 1981, p. 3.
42. *Ibid.*, p. 177.
43. *Ibid.*, p. 209 and p. 164.
44. *Ibid.*, p. 92.
45. *Ibid.*
46. *Ibid.*, p. 164.
47. *Ibid.*, p. 196.
48. *Ibid.*, p. 93.
49. *Ibid.*, p. 118.
50. I. Qadeer, "Reshaping Health Services: A Note on Draft Plan on Rural Health Services", *EPW*, 1977, p. 927.
51. Desai, in his analysis of Panchayat Raj emphasized this class dilemma of rural communities: "The control of Panchayats by rich landholding groups which also come from upper or upper intermediate castes raises some fundamental issues. Can an administrative machine, though elected on universal franchise, really become an instrument of the poorer sections, and adopt measures which will be at the cost of the richer sections, if the fundamental framework of socio-economic formation is perpetuated on exploitative class lines wherein a small section of the rich landowning class dominates and controls the economic life of the people? In the context of class-relationships prevailing in rural society, will not the Panchayat Raj administration, become tools to subserve the interests of the rich?" (in *Rural Sociology in India*, Popular Prakashan, 1978, p. 533).

52. *Health For All*, *op. cit.*, p. 188.
53. See, *An Alternative System of Health Care Services in India: Some Proposals*, Allied Publ., 1977, p. 11. Banerji also describes this tendency for local collaboration between village-level government functionaries and the rural elite: "While many of the government functionaries are required to work closely with the village population and get them involved in development programmes, because of their class background and the nature of their socialization, in most cases they tend to keep themselves as much aloof from the rural population as can be helped under the circumstances. The most significant aspect of this relation is that when the political and administrative pressure can no longer be eluded, these officials develop linkages with the group which is to them politically most important, economically most rewarding and socially least desirable, namely, the privileged classes of the village population. In their turn, the privileged classes get further strengthened with such linkages with government functionaries of various kinds" (*op. cit.*, 1982, p. 150).
54. *The Political Economy of Health*, *op. cit.*, p. 289; emphasis added.

PART IV

Political Action for Health Change

Introduction

Based on a deeper understanding of the forces in society which keep people from being healthy, it becomes possible to re-interpret what action is ultimately required to alter the ill-health reality in the country. In this final section of the book, we will therefore consider the meaning of, and possibilities for, 'political action for health justice'. To do this, we will look at two examples of such action already *in process* in India. The first chapter will study the socio-political background to the significant improvement in health status in the state of Kerala, the only area of the country where infant mortality has substantially decreased since Independence. Then we will explore ways in which health workers can contribute to a socio-political change process, by looking at the experiences of various health workers and mass organizing/political movements in other parts of the country.

CHAPTER VIII

Kerala: A Beginning

One State of the twenty-two is unique within the country for the major improvement in health status which its people have achieved. So significant are these health changes in Kerala that any analysis of health in India is obliged to consider how and why they have come about. For example, the infant mortality rate in Kerala in 1971 was 55 (per 1000 live births), considerably less than half the rate for the country as a whole. Kerala has also witnessed the greatest decline in birth rate. What is perhaps even more interesting is that these changes have occurred in spite of Kerala remaining poorer and industrially less developed than many other states in the country. Admittedly, there is still room for considerable improvement in health status. Yet the achievements deserve consideration.

In a review of the health and fertility changes in Kerala, Ratcliffe summarizes: "Kerala is a small, densely crowded state in South India. It is a poor state, even by Indian standards. Its per capita income of US \$ 80 lies well below the all-India average of US \$ 120, and it suffers from the lowest per capita caloric intake in India. Nevertheless, Kerala has managed to achieve the demographic transition from high (premodern) to low (modern) birth and death rates — something no other Indian state has been able to attain... Other indices of Kerala's social development are equally surprising: level of literacy, life expectancy, female education, and age of marriage are the highest in India, while mortality rates, including infant and child mortality, are the lowest among Indian states."¹

How does Kerala differ from other states which might account for these changes in health status?... It is clear that the factors and social phenomena immediately responsible for improvement in health are recent, the major drop in infant mortality beginning in the decade 1951-1960. What was happening in Kerala during this period that was not occurring, or at least not occurring in such a substantial way, in the rest of the country? This chapter offers one hypothesis to explain these changes. To do this, we will refer to a number of articles by social

analysts which seek to interpret the forces behind these health changes, as well as referring to a more detailed background document, *Poverty, Unemployment and Development Policy*.²

To begin with, Kerala's higher health status is not due simply to numbers of medical/health facilities, as Panikar has carefully documented. 'Many states with very much higher death rates have a higher proportion of doctors and hospital beds per population than does Kerala. For example, the doctor: population ratio is 1:4742 in Kerala compared to 1:1988 in Rakku's neighbouring state of Tamil Nadu. Likewise, many states have higher medical and public health expenditures per person than Kerala. But if extra medical expenditures are not responsible, then what is?

First, it is important to consider *when* these various social, health and demographic changes took place in relation to each other; that is, to place Kerala's health change within a historical context. Gulati has summarized changes in literacy, age of marriage of women, and birth and death rates during this century. 'Her data indicate that the age of marriage of women was already considerably higher in Kerala than in the rest of the country at the turn of the century; yet infant mortality did not begin to fall substantially until the 1950s. Furthermore, this drop began at a time when literacy was still only about 40%. Significant decreases in Kerala's birth rate began a decade later in the 1960s.

There have been many explanations offered for Kerala's improved health status. The most commonly cited is that of education, literacy presumably leading to greater awareness of the value of modern health care. Yet education by itself can hardly be a sufficient explanation either, for there are other states with continuing high infant mortality rates where literacy levels, even for women, are similar to those in Kerala (38%) when that state's infant mortality had begun to drop significantly.³ As well, it is difficult to accept that the present differences in literacy between Kerala (69%) and, for example, Tamil Nadu (46%) could adequately explain the very large difference in infant mortality rates between the two states — infant mortality in Tamil Nadu being double that in Kerala.

What does distinguish Kerala from the rest of India are the exceptional socio-political developments in the state in the earlier part of this century — changes which saw many landless labourers and tenant farmers beginning to organize among themselves. By the 1930s deteriorating conditions, especially for agricultural labourers, led to mass movements demanding radical agrarian change.⁴ Jose clearly documents these political movements,⁵ and describes how the

adoption of capitalist farming methods increasingly limited employment and tended to push smaller peasants off their land. In response, the labouring population joined to form strong agricultural unions. This growing political consciousness and power eventually led to the 1957 election of a state government (the Communist Party of India) committed to implementing the radical land reforms talked about by the central government. Opposition to these reforms has been intense, limiting their full implementation. Yet the momentum of popular pressure has continued to shape the direction of subsequent public policy.⁸

In addition to land reforms, agricultural labourers have, since the late 1950s, pressed for increases in, and enforcement of minimum wage and child labour laws which in other states have generally been ignored. Reforms have also included a degree of security for wage labourers, and welfare and pension funds.

The strength behind this popular movement also led to policy decisions which massively redistributed public educational funds. For example, by 1970-71, 63% of Kerala's educational expenditures were channeled to primary schooling, and 86% to primary and secondary combined.⁹ As a result, youth illiteracy (5 to 15 years) has effectively been eliminated and functional literacy in the older adult population is increasing at a rapid rate. In comparison, at least half of all educational funding for the country as a whole continued to be concentrated on post-secondary education and only 29% on primary schooling.¹⁰

In a similar way, the new government committed itself to food redistribution by establishing a network of "fair price" shops throughout the rural as well as urban areas of the state, thus making grain staples equally accessible at controlled prices. Interestingly, in spite of Kerala having one of the lowest per capita calorie intakes in the country, it also has the lowest incidence of childhood malnutrition.¹¹ Likewise, the government has put emphasis on primary health care and extension of these services throughout the rural areas. Yet as we have seen, numbers of hospital beds, doctors and health expenditure alone cannot explain the improvement in health compared to the rest of the country. What does distinguish Kerala from every other state however, is the significantly higher utilization of health facilities by the people.¹²

What accounts for this higher utilization of health services by Keralites? Higher wages and some degree of job security are likely to reduce some of the economic barriers to obtaining health care.¹³ But the general level of politicization of working families, and hence

pressure "from below" for accountability from public services, is undoubtedly a major factor as well.¹⁴ As one Keralite explained, "If a health centre doctor doesn't give proper care the people now are likely to protest, either by reporting to local officials, by sending a letter to the local newspaper, or by directly confronting the doctor themselves". While this degree of understanding of individual rights may not yet be present in all Keralites, the fact that this attitude exist at all is quite remarkable, even from the perspective of nearby Tamil Nadu. Mencher, in a comparison of rural health services in Kerala and Tamil Nadu, similarly concludes: "The main reason I could see for the differences between the two states was political awareness: in Kerala, if a PHC was unmanned for a few days, there would be a massive demonstration at the nearest collectorate led by local leftists, who would demand to be given what they knew they were entitled to. This has had the effect of making health care much more readily available for the poor in Kerala".¹⁵

Yet is it likely that higher hospital/clinic utilization rates themselves account for, or are even the major factors leading to the fall in infant mortality? Probably not. For utilization rates alone would not explain the significantly lower level of under-nutrition in young children. And as many Keralites have pointed out there are still major lapses in the public health services.¹⁶ As well, there continues to be elitism and corruption in the upper stratum of health services, particularly hospital services, although it no longer remains entirely unopposed.¹⁷ On the other hand, even a marginal improvement in job security would allow families to take care of young children better and would give them a small but infinitely significant "freedom" to tend to their needs when ill. Likewise, a growing consciousness of their rights, and collective capacity to ensure those rights, now makes it "rational" for them to seek out the benefits of various government programmes, whether health services, fair price shops or education facilities — which together would at least indirectly improve their economic situation and general standard of living. This is in stark contrast to the "rationality" of Rakku NOT seeking care at the rural health centre in her Block, for she cannot risk the lost wages and increasing debt for services which she is in no way sure of obtaining.

In his recent study of peasant organizations, Alexander observed a "rejection of traditional values, ideology and relational norms" in the Kerala district he studied, in sharp contrast to areas of Tamil Nadu and Karnataka.¹⁸ "Customary practices like untouchability and deferential signs are seldom observed in Palghat. The practice of labourers addressing farmers with honorific words also is disappearing". Such

major changes in consciousness among the labouring population reflect the rapid changes in farmer-labourer relations which have occurred in the State, and shifts in political power.

It is often emphasized that "Kerala's successes have been achieved not by allocation of more resources, but rather through a more equitable distribution of existing resources, goods and services".¹⁹ Yet "equitable distribution" is hardly an adequate explanation in itself. For the drafting and enforcement of redistributive policies did not occur simply by chance — did not appear simply through a fortuitous arrival of particularly enlightened leaders on the political scene. Rather, such policies intimately reflected, and were a product of, the emergence of an increasingly politicized base of consciousness and action from much of the labouring poor — which in turn, as Jose documents, was a response to fundamental changes in agricultural production relations. Such pressure by the rural poor required prolonged and courageous organizing, a process which grew in intensity throughout the 1930s and 1940s, and which continues to this day. In other words, the forces responsible for the redistributive policies came not primarily from above, but *from below*. Such organizing has created among the poor a collective awareness to expect and demand a fairer deal, as well as a consciousness to make use of basic services as they became available. In other words, the potential value of specific programmes has been broadly realized precisely because of the underlying politicization of the people. As Mencher also argues, "The reason why people are living longer, and why child deaths have declined, relates as much to politicization of people as to public policy".²⁰ Such a hypothesis is hardly suited to the standard methods of "empirical" measurement; yet the significance of politicization is compellingly apparent.

In this overview of the health changes in Kerala, little emphasis has been given to the changes in fertility rates which have also been occurring in the state. This is in part because this analysis concerns health, and there is little evidence that birth rate reduction by itself would improve the health status of children of individual labouring families. It is also because so much attention has already been given to Kerala's declining birth rate, often in the context of Kerala being a "model" for population control for the rest of the country. Much of this writing however has been based on rather superficial analysis. Kerala has become a "cheap model for development"²¹ — "cheap" in the sense of appearing to have solved the "population explosion" problem without radical structural changes in its political economy being required.

To examine the limits of Kerala as a "development model", it is important to explore the reasons for its falling birth rate. Several initial comments are necessary. First, the decline in Kerala's birth rate began in the early 1960's, that is, *before* the intensification of the national Family Planning Programme. Nair concludes that the drop in birth rate, rather than being initiated by official population control efforts, was a response to "some kind of broad societal adjustment".²² Indeed, in the late 1960's, Kerala ranked only fifth in Family Planning acceptance rates.²³

On the other hand, there can be little doubt that the major improvement in child survival in the state has contributed to some degree to the declining birth rate.²⁴ Yet it is unlikely that better child health is an adequate explanation in itself. An equally important factor may be the *declining economic value of children* to labouring families. The fact that families in Kerala are limiting family size is in part a response to the very high and increasing levels of unemployment within the state.²⁵ But other factors as well have contributed to the declining economic value of children. For example, the greater resistance to exploitative work relations generally in the state has also led to much more effective enforcement of child labour legislation.²⁶

Clearly, the factors contributing to Kerala's declining birth rates are complex. Suggestions therefore that the state represents a "model" for development are simplistic — if by development we mean decreasing societal poverty (ie. increasing the productive forces) in addition to democratic and non-exploitative socio-economic relations. The major improvements in literacy, health and "sense of freedom and human dignity" in Kerala are real and extraordinarily significant. Yet poverty remains, unemployment increases. This should hardly be surprising however, for distributive policies alone, as important as they are, can hardly be expected to eradicate societal poverty. Economic development requires a planned and massive churning back of surplus value into investment which will increase the productive forces throughout the state. Due to the still limited nature of land reforms (and to resistance to these measures both from within and outside the state), considerable agricultural surplus value continues to be diverted into less productive personal consumption. At the same time, private capital flees the state in search of cheaper, non-unionized labour — a predicament which highlights the inherent structural limitations for Kerala as a *single state* within the country to radically transform its own political economy.²⁷

The people of Kerala have yet a long way to go in transforming their

state into an egalitarian economically-developed society — a struggle which ultimately must be linked with similar political change in the rest of the country. But for the purposes of this study, the nature and process of social change in Kerala has undeniable implications for an understanding of ill-health in the rest of the country. It suggests that improvement in health status is in the final analysis more related to increasing political consciousness and organization than to any specific health/medical technology.

In the final chapter of this book an attempt is made to situate the meaning and source of ill-health within a political framework, and to define what "political action for health" implies.

NOTES

1. J. Ratcliffe, "Social Justice and the Demographic Transition: Lessons from India's Kerala State", *Inter. J. Health Services*, V.8, No.1, 1978, p. 123.
2. *Poverty, Unemployment and Development Policy: A Case Study of Selected Issues with Reference to Kerala*, Centre for Development Studies, Trivandrum, Orient Longman Ltd, 1975.
3. P.G.K. Panikar, "Resources Not the Constraint on Health Improvement: A Case Study of Kerala", *Colloques Internationaux du C.N.R.S.*, No. 582 — *Asie du Sud, Traditions et Changements*, pp. 549-55.
4. L. Gulati, "Age of Marriage of Women and Population Growth", *EPW*, 1976, p. 1225.
5. Female literacy in Kerala for the decade 1951-60 was 38%, compared to 34% in States such as Tamil Nadu and the Punjab in 1981. On this, see Gulati, *op. cit.*, Table I, p. 1227; and Registrar General of India, *Census of India, 1981, Series I, Provisional Population Totals*, New Delhi, 1981.
6. *Poverty, Unemployment...*, *op. cit.*, p. 59.
7. A.V. Jose, "The Origin of Trade Unionism Among the Agricultural Labourers in Kerala", *Social Scientist*, V. 5, No. 12, 1977.
8. *Poverty, Unemployment...*, *op. cit.*, p. 59.
9. *Ibid*, p. 126.
10. D. Barreto, *Analysis of the Indian Situation*, Centre for Social Action, Bangalore, p. 27.
11. *Child Atlas*, UNICEF, New Delhi, 1981.
12. *Poverty, Unemployment...*, *op. cit.*, p. 139.
13. Saradamoni points out that "the hours of work fixed by the labour legislations enable the labouring women to get off the fields earlier than what they were able to do in the past... Women have (also) benefitted from legislation on... wages, etc, even if they have not brought about parity with men" (in "Women's Status in Changing Agrarian Relations: A Kerala Experience", *EPW*, 1982, pp. 157 and 162).
14. "Corrupt Doctors: The patients have lost patience", *Caravan*, April 1981; p. 17,

which describes a public ("people's court") trial of a government doctor.

15. J. Mencher, "The Lessons and Non-Lessons of Kerala: Agricultural Labourers and Poverty", *EPW*, 1980, p. 1782.
16. See, for example, K.J. Mathew, "Health Care in Kerala", *Social Scientist*, V. 8, No. 3, 1979, p. 56. As well, Panikar observes that "even today the proportion of the population covered by protected water supply and sewerage in the rural parts of Kerala remains rather low" (in *Colloques Internationaux*, *op. cit.*, p. 556).
17. See above, note 14.
18. K.C. Alexander, *Peasant Organizations in South India*, Indian Social Institute, New Delhi, 1981, p. 179.
19. Ratcliffe, *op. cit.*, p. 133.
20. For a critique of such analysis, see both J. Mencher, "Agricultural Labourers and Poverty" *EPW*, 1982, pp. 38-44, and P.G.K. Panikar, "Towards Demystifying Kerala's Fertility Experience", Working Paper No. 122, Centre for Development Studies, Trivandrum, Jan. 1981.
21. Mencher, 1980, *op. cit.*, p. 1781.
22. P.R.G. Nair, "Decline in Birth Rate in Kerala", *EPW*, 1974, p. 327.
23. National Institute of Family Planning, "Demographic Situation in India", GOI, 1974.
24. T.N. Krishnan, "Demographic Transition in Kerala", *EPW*, 1976, p. 1203.
25. Mencher, 1982, *op. cit.*
26. In spite of high rates of unemployment and underemployment in other states, children are still of economic value because of lower minimum wages laws and poor enforcement of existing child labour laws. On this, see, for example, note 5 of chapter one.
27. Other continuing socio-political problems in Kerala include tensions and conflicting interests between various agricultural groups, specifically between agricultural labourers and former tenants who are now small landowners as a result of tenancy reforms and land redistribution. On this, see J. Mencher, "Agrarian Relations in Two Rice Growing Areas of Kerala", *EPW*, 1978, p. 349. Saradamoni also highlights the major struggles for women's rights which still lie ahead (in "Women's Status in Changing Agrarian Relations: A Kerala Experience", *EPW*, 1982, p. 155).

CHAPTER IX

The Necessary Focus for Action

It is easy to say that health is a political issue and therefore cannot significantly improve until there are radical structural changes throughout society. But what does this mean, practically speaking, for the socially conscious individual who because of her* skills chooses to be involved in issues of ill-health and health care? This final chapter is offered as a practical interpretation of what such a theoretical understanding of ill-health implies. It is not a formula for action; but rather, broadly considers how issues of ill-health can be used to contribute to the national struggle for health and social justice.

1. Social Action: Personal Involvement

In chapter two we looked at the major causes of ill-health and mortality in children and adults. We saw that five or six diseases account for most of the excess mortality in the country, and that technically speaking at least, these "diseases" are easily prevented or treated, even at the village level. The mechanics of basic health care then are neither complex nor prohibitively costly.¹ But we also considered how even the best organized health programme is limited in what it can achieve by factors such as malnutrition of both adults and children, inadequate child care due to working conditions for labouring women, and the inaccessibility of basic curative services when required — limited, in other words, by poverty, the source of which is the social order itself. The health worker then must face the difficult but essential question: whether to apply "social band-aids" by exclusive involvement in the mechanics of health care delivery; or whether on the other hand, to work at the level of "alternative relationships" of power between classes of people in society.

Let us first consider the decision at the individual level. To work at the "source" of the problem requires, and perhaps pre-supposes, the cultivating of an analytic and questioning frame of mind; a way of

* In order to avoid the somewhat distracting use of her/his in referring to the individual health worker, the two genders will be used alternately in the remaining sections of the book.

thinking which seeks a deeper understanding of social problems, and of one's own relationship to those problems within society. This way of thinking is unsatisfied with the present mystification of ill-health and social injustice, as for example the description of poverty as "an extremely tenacious disease". It rejects the vagueness in which liberal thinking encloses deep social problems and contradictions, as if poverty were simply falling from the sky. Instead one must seek the clear observable social relations and economic forces which lead to and determine that poverty. And hence to understand and re-define the very term "poverty" as instead, a man-made condition.

In Rakku's case such critical thinking would lead to a truer understanding of why her child dies. While she may be yet immersed in "ignorance and superstition", these are not the real cause of her child's death. Nor is it the heavy workload at the hospital. Her child dies because she is too poor, and she is too poor because her entire existence is bound by the economic and political structures of society which determine the exploitation of her own and her family's labour.

Such *critical thinking* would also lead to an awareness that explanations for social problems do not require experts; that such problems cannot be solved simply by technicians or bureaucrats, whether in a national health ministry or international agency. In effect, critical thinking leads to the discovery that the explanations are readily at hand for anyone who has the courage to look and reflect.

Beyond this questioning and analytic frame of mind, there is the need to re-examine the liberal notion of "neutrality" — the belief that it is possible to "sit on the fence" with regard to social problems and injustices. Or the belief that as a health worker one can claim exemption from addressing these deeper issues as long as one is conscientiously using one's technical skills. Rakku's story suggests otherwise. It suggests that, on the contrary, if one is not consciously addressing the roots of ill-health, then as a member and beneficiary of the existing social order, no matter what one's good intent, one is contributing to the continuation of that order — and therefore to continuing ill-health as well. The question then becomes: *How* can a health worker also work at the source of ill-health, at the level of alternative relationships between classes in society?

Examining Current Health Care Ideology

One level at which an individual health worker can participate in social change action is by contributing to an economic and socio-political interpretation of ill-health; that is, to analyse and explain the

societal roots of the health problems being confronted within one's daily work. For example, instead of lamenting the "ignorance" of a dying village woman brought to a clinic for a difficult childbirth, the health worker can point out the barrier of poverty which prevents her family from bringing her to medical care sooner; and at the same time expose how the organization of the health services can create further barriers. Likewise, there is a need for factual recognition of the limited role of medical techniques in improving health in society. Coming from health professionals, such analysis can contribute to weakening the medical-model ideology which continues to dominate and thus legitimize the status quo. Indeed, there is a continuous need to expose and challenge the ideological content of positions taken by the medical establishment or contained in official health policies. So neglected is this whole area that it will be useful here to consider one recent example in detail.

In the critique of the "medical model of health" in chapter seven, we considered how interpretation of physical or social reality can be shaped by ideology. Such an ideological influence can clearly be seen in the current debate over the definition of the "poverty line" — a debate which contains profound health and political implications. The debate has involved criticism by P.V. Sukhatme of the extent of undernutrition he feels is implied by the poverty estimates given by Dandekar and Rath's 1971 report, *Poverty in India*.² Sukhatme accepts that a significant proportion of the population is smaller in size (body weight) than properly nourished people should on average be. But he argues that many of the poor have successfully adapted to lower food intakes and are not necessarily unhealthy. ("The body build of children living on intakes smaller than the average was certainly small, but the inference that they were either undernourished or anaemic or otherwise not healthy was found to be unwarranted on biochemical examination of their blood."³) He therefore concludes that the official minimum food requirement, as a measure of poverty, should be lower than for individuals with normal (ie. optimal) weight. ("It is necessary to adjust intake data for body weight before comparing it with the expected distribution of requirement."⁴) In other words, because of this "adjustment" capacity of the poor, it would be misleading to apply the minimum nutrition standard for well-nourished Indians to the population as a whole when seeking to "define" poverty.

Dandekar replies that Sukhatme's statistical methods and analysis are faulty,⁵ and that the experimental data on intra-individual variation upon which he bases his argument are inadequate and inappropriate.⁶

Dandekar also points out the dangers of "vested interest in a pseudo-scientific proposition". For assessment of these two positions the reader is encouraged to refer to the original papers.

I agree with Dandekar's position. More importantly, what is revealed in Sukhatme's argument is more than fuzzy statistical thinking. One is also compelled to ask what the consequences are of Sukhatme's theory. Several critics⁷ have warned that Sukhatme's argument can lead to a "politically-expedient" re-definition of poverty: lowering the required food intake allows those in power to minimize the "problem" of poverty, or even re-define it out of existence. But this debate is also important in the way it reveals the role of ideology in shaping the way people perceive social issues. And it is because health standards are being used as a vehicle for promoting particular ideological positions that the health worker's role in this debate is so important.

What is meant by "ideological position"? Ideology refers to a system of socio-political beliefs which is not scientific, but rather, is comprised of opinions and values which are derived from the social position of the people originally expressing them. It is crucial then to find out whose "opinions and values" are represented. The statement that lower (than optimal) body weight for one section of the population is not a problem, that it is acceptable, is not scientifically based. (In fact, the correlation of increasing disease and mortality rates in adults and children with decreasing income and food expenditure suggests precisely the opposite.) It is thus an ideological position, as Sukhatme interestingly admits: "What constitutes the expected level of physical activity and body weight depends on culture, ideology and other factors."⁸

The point is that Sukhatme's conclusions are a prescription not for himself, but for others — for the labouring poor. His position contains two elements. First, a rationalization of two different standards of physical life. And second, an implicit justification of the powerlessness of those in the lower nutritional standard to choose for themselves which standard they will belong to, or to challenge the double standard itself. Thus Sukhatme's argument is ideology of and for the ruling class.⁹

This is even more clearly revealed in Sukhatme's interpretation of why the issue of hunger is important. He explains: "A hungry man is a social liability. He cannot work... he will retard economic and social development".¹⁰ Now Sukhatme's meaning of "hunger", it appears, is not the ordinary meaning. There is no doubt that landless and

subsistence-farming families suffer acute hunger for varying parts of even an average year, as Banerji's recent studies document,¹¹ and as is immediately evident in most villages. Obviously, this is not the hunger which Sukhatme has in mind. What kind of hunger then is he concerned about?... Hunger which redounds upon society; hunger which is, in his own words, a "social liability". In other words, hunger which interferes with the work output of the poor,¹² and thus is a liability to those who presently benefit from that labour. Hunger therefore which upsets and threatens the socio-political status quo.

Highlighting the *ideological content* of Sukhatme's argument raises the more important question as to the *source* and support for such thinking within the social order generally. In other words, it is not surprising that one individual should hold such beliefs. But the fact that such a position has received much attention and sympathy within a significant portion of the scientific community and ruling class as well¹³ makes critical response necessary.

What distinguishes Sukhatme's position is the rationalization of differing standards for physical life — and inherently, for physical well-being and survival. Such an ideological position is an implicit declaration of "class war". Yet at the same time, so forthright a statement is hardly surprising. For it can be expected that as the contradictions in the social order deepen and thus exacerbate the economic and political crisis in the country, the "democratic" and "socialist path" rhetoric will increasingly be discarded — slogans which in the past have served "as useful frills or covers for the reality of strengthening of the various vested interests in the Indian political economy".¹⁴

What enables Sukhatme to bypass this crucial ideological issue — in a sense, to remove it from debate — is his sudden emphasis on the technological needs of the poor (such as water and environmental hygiene and sanitation). In this way attention is taken away from the central issue, namely the distribution of economic power and therefore, food. Instead, he shifts the discussion to a technical focus which is "safe" — safe, because the ruling class maintains control as "distributors" of such benefits. The heat is off, so to speak, and the poor become once more the passive recipients of handouts from those in power. Furthermore, in case anyone is still left with questions, access to this immanently social-political debate is denied them by submersion of the argument within unnecessarily abstruse statistical language.

Three basic issues are revealed by Sukhatme's position in the

poverty line debate. The first is the degree to which ideology shapes the interpretation of social reality — in this case, the very definition of health. The second shows how powerfully ideology can appropriate scientific tools to serve the interests of a particular group in society. And the third raises the question of where the health profession stands in this debate. Curiously enough, it has been an economist, rather than a nutritionist or health worker, who has most clearly challenged Sukhatme's argument. Yet it is health workers who are most immediately confronted with the human consequences of undernutrition and ill-health... The potential role of health workers in challenging health injustice and the ideological beliefs which rationalize such injustice is undeniable — and, one might add, yet unrealized.

Social Health Research

In addition to exposing ideological positions relating to health care and ill-health, basic research into the relationship between poverty and disease must be carried out. One example would be collecting data on TB deaths by socio-economic class, urban and rural. For rural TB data, this would particularly involve deaths of villagers who never even reach TB clinics to be registered as cases. Another example: simple documentation of what the labouring poor manage to eat over the course of a year, and what such a diet implies for health;¹⁵ or careful analysis of the costs to the poor in seeking health care, in terms of lost wages, travel, interest on loans, medicines, as well as fees charged by the voluntary health institutions.

At the same time, *this basic research must be offered back to the people whose lives it describes*, rather than being lost to them in inaccessible medical journals and documents. Social health analysis thus represents an invaluable opportunity for raising basic questions among the poor, establishing a beginning analysis of their collective predicament and re-inforcing the validity of such questioning. Admittedly, the scope for social health analysis within existing medical institutions may be rather limited. Predictably, such efforts will be discomfiting and even threatening for many official and voluntary health institutions. Thus the implications for job security are not insignificant! However, the exact scope for such analysis which may be possible within established institutions remains to be fully explored.

As useful and needed as such social health research may be, however, is it realistic to expect that even such efforts could bring about any substantial change within the profession and health services as a whole? Placed within a market economy framework, the practice of medicine acquires an internal dynamic which resists appeals to

social relevance.¹⁶ What action, then, might have broader significance for social change? Indeed, can working at the "source" of ill-health be done within the realm of health activities at all? This is of course the key question for the individual health worker interested in social change. It is always easier to identify a problem than to know how to take part in solving it! In the following pages the experiences and thoughts of a number of health workers and activists are considered in an attempt to define what role there may be for health action within the broader struggle for social transformation.

2. Social Action: Collective Involvement

From the example of Kerala it becomes clear that action for health change must include collective action to create pressure *from below* for the re-distribution of health resources and skills and accountability for those services. Only such an organized response can hope to challenge the forces and interests which maintain the system as it is. *Advocacy* for this struggle is a central task of the health worker. Her presence in a community with a visible commitment to the labouring families can be a significant source of strength. But in what way can the health worker best fill the role of advocate? In the last few years various perspectives have emerged.

Health as an "Entry Point"

As we have seen in earlier chapters, the influence of isolated health projects on the national problem of ill-health is limited. Recently however, health care activities have been presented as useful points for involving communities in organizing themselves politically. Since issues of ill-health are less intimidating (than, for example, land reform) they may serve to begin a process of collective questioning and organizing. It is argued that such efforts can lead to greater consciousness and create a base of solidarity for the poor to confront the more difficult, and admittedly more important, social issues.

But using health activities as an "entry point" for the mobilization and organization of the poor creates special problems. First, providing even an initial health service of itself creates an additional dependency within the community to maintain that "clutch" or substitute service. This is understandable, considering the immediacy of health needs which are often life-death issues. But because dependency is precisely the condition which determines their ill-health in the first place, it is essential that the rural poor collectively control the activities of the health programme and the participation of the health workers themselves. If this control is real, it may to a certain extent

counterbalance the additional dependency created by the substitute health activities.

Theoretically at least, it has been suggested that the health entry point can lead the labouring families to organize themselves to pressure for changes in other areas, such as minimum wages, land reforms, adequate day care/creches for young children, and so on. But the transition from health entry point to broader socio-economic issues is not easy. The political demands of such broader action make it likely that the health workers and some individual villagers will draw back, fearful for the survival of the health project itself. But clearly, to draw back at this stage deprives the health activities of any societal meaning and reduces the effort to that of providing health care to one or a few of the six or seven lakh villages in the country. Such limited action neither touches the basic cause of ill-health in that community, nor does it contribute to societal change.

The problems encountered in this essential "transition" are common. Several rural health projects have recently begun to discuss the difficulties involved in trying to move beyond health-related activities.¹⁷ Their experiences call in question the validity of the "entry point" concept. In actual practice, there are few comprehensive rural health projects which have moved significantly beyond their original health focus. Chapter six has already described some possible reasons for project organizers to be reluctant to involve themselves in broader economic and political issues. In part this reluctance may stem from the socialization process of health workers, a process which may have made them especially unwilling to participate in an egalitarian relationship with the oppressed. As well, it may reflect the constraints imposed by health care work itself. The costly nature of many health care activities — relative, that is, to the disposable income of many village families — makes some degree of external funding unavoidable, a situation which creates inherent limits and controls to the activities. This is so whether the external funding source is a development agency per se, or income from fees selectively charged for curative services. On the other hand, the tensions arising from broader political action inevitably jeopardize continuation of such funding. This creates an anguishing dilemma for villagers receiving life-saving care — for example, TB treatment. For to support such action might very well risk continuation of their treatment. At the same time, project health workers themselves may be reluctant to risk the security of their own jobs and income. It therefore becomes important to recognize these difficulties. Indeed, some health workers would even consider them an absolute barrier.

The Health Worker as Activist

Perhaps in response to these difficulties a growing number of health workers in the country are choosing to work within a broader social action framework — a framework in which the main objective is the political organizing of the rural poor. Within such work, specific health action is simply seen as one of many issues around which the poor can organize and act.

In choosing to work at this level the health worker commits himself to work with the labouring people in order to bring about fundamental change in the social order. In this way, the health worker accepts the role of an "activist". In the remaining pages we will refer to one who has made this social commitment as the "health worker as activist". The decision to work within a broader political process, also means choosing to work simply as one member of a team consisting of villagers and other activists from beyond the community.

What then is required of the health worker as activist? To take part in social action which seeks alternative relationships between classes in society demands an awareness of one's own position within the social order. As an educated, skilled member of the elite, the health worker himself belongs to the dominant class. There is thus a need to recognize and come to terms with the assumptions and mode of thinking which he has inherited from his privileged origins — a sense of superiority, a need for control and power, a paternalistic attitude towards the "poor". For only if a relationship of genuine equality and mutual respect between villagers and health worker is established *from the beginning* can the health worker as activist avoid increasing dependency as "possessor" and "distributor" of special health skills.

Beyond this, involvement in social action requires a deep commitment to the exploited majority. But such an attitude presupposes an understanding of the *historical* process of social change itself. Commitment to the oppressed means conscious participation in the historical process of creating a "more fully human" society. Thus the activist health worker must possess a *theoretical* understanding of the process of social change in India. By theoretical understanding is meant a deepening study of *why* poverty is increasing, and an awareness of the conflicting interests between those who benefit from the present social order and those who do not. It involves analysis of the conditions which lead the poor to question and reject the legitimacy of both economic exploitation and inequalities, and the traditional and cultural beliefs by which they are justified. It means analysis of the varying factors which have already

led to growing collective consciousness and action in different parts of the country. Thus, it involves a study of the existing and growing popular forces for change, both as political and mass movements.

All this compels the health worker to become a student once again. Yet placed within a *continuous* study of the economic, political and social forces which determine ill-health, the technical information and skills of a health worker can be transformed into the basic tools of "social medicine" — as perhaps originally foreseen by Virchow, and as realized to a good extent in some socialist countries.

Based then on practical and deepening social analysis, what is the specific contribution of the health worker in social change action? Specific health action within a broader movement first of all creates awareness that children and adults do not have to die of simple illnesses. Responding to a specific health problem can thus *help change an unquestioned assumption regarding the condition of their lives* — an experience which can potentially lead to their questioning poverty and exploitation as well. At the same time, the activist health worker can lead the poor into sustained questioning of *why* health services are not accessible to the people through the existing health system. Such collective questioning can lead the people to make demands on the government and health agencies for such services — an act which *re-inforces a consciousness of the legitimacy of struggle and organization*.

Furthermore, organizing around health issues presents a special opportunity for *uniting the oppressed*, since the social injustice revealed by ill-health is a common condition for all of the labouring poor. Thus, for the health worker particularly the potential exists for enhancing solidarity among the various castes and sub-castes of the poor in the community, divisions which otherwise inhibit awareness of the ultimate source of their poverty, and likewise hinder action. For it is not only Rakku as an "untouchable" who loses children, but all of the labouring poor regardless of their caste.

But the immediate aim of organizing around health issues can hardly be the transformation of the entire health system — a goal which would require similar organizing throughout the country. Instead, the more immediate goal is an initial change in consciousness — the essential first step of questioning and rejecting not only the inevitability of ill-health, but also their overall powerlessness in society. For example, a group of activists working in a tribal area in Bihar initially found that one of the most immediate needs of the people was health related. For the villagers, endemic malaria was causing a great

deal of physical suffering, but had enormous economic implications as well. In teaching them how to treat malaria, the activists (one of whom was a nurse) were able to gain the confidence of the people. Building on this confidence, they could initiate questioning about the absence of government services generally. While the people at first organized to confront the health authorities, they gradually came to channel more of their organizing effort into economic and legal issues.

To organize and pressure for accountability from the existing health system is more than an isolated "tactic" in the struggle against ill-health. The deeper meaning of such action is that the people directly experience their collective capacity to act, resist and challenge structures which do not serve their interests. As rural activists in Tamil Nadu describe, "For tactical reasons, the programme initially stresses the need to rally against (particular) social problems... The people together with the group confront government authorities in order to secure their rights... This is not an end in itself but a necessary means that serves to inject hope and build confidence in the people to carry the struggle forward and transform society completely."¹⁸

In her day-to-day action, then, the activist health worker can encourage the poor to seek a clearer understanding of their ill-health and hunger within the social order of the community and beyond. In doing so the activist provides an opportunity for the poor to see alternatives to the existing relationship between classes, and to discover their own capacity to change and humanize those relationships. In many rural areas however, the most immediate concerns around which the poor will choose to act may not be health related at all. In areas with large proportions of landless labourers, for example, organizing around economic issues may be immediately possible and more appropriate. Health issues, on the other hand, may be more useful as an initial focal point for action in those areas where economic contradictions are less visible and acutely defined.

There is a small but growing number of nurses and doctors in India who have abandoned altogether their technical skills and instead have committed themselves to full-time social analysis and organizing work with the masses. Their decisions are based on a recognition, often through previous rural health experience, of the primacy of economic and political injustice in creating ill-health. Admittedly it is not likely that many health workers who are interested in social justice will make such a commitment. Yet the framework for progressive health action is clear: action which enhances the capacity of the oppressed to confront the existing health and social order, in order to transform it collectively.

3. The Process of Consciousness-Raising and Organizing

Organizing by the poor is the central process in the struggle for social change. But for the oppressed to organize effectively requires more than the moral support of an advocate in their midst. It also demands the painstaking process of consciousness-raising — a term which unfortunately has been somewhat trivialized into fashionable development jargon.¹⁹ Here we will try to consider its original meaning.

Generations of utterly precarious existence and dependency have made the poor fearful of challenging the forces which control their lives — a fear which is entirely rational. For the wage labourer, such fears stem from the brutal absence of alternatives to sustain life. Thus he comes to accept his condition and even believe in the prevailing social theory explaining his oppression — that is, the natural inferiority of those who labour. In India, this belief system is openly embodied in the notion of caste. For Rakku, the pain of her child's death and her own powerlessness to prevent it, drives her to an acceptance of "fate" and karma as an explanation to ease her *otherwise intolerable* anguish — though the real cause of the child's death is also clear to her.

But along with this acceptance of their inferiority, the poor come to accept as "natural" the oppressors' very interpretation of social and human reality: they learn to see the world as *inevitably* divided between oppressors (those who control the labour of others) and oppressed (those who are bound to sell their labour and indeed lives). Not surprisingly then, in initial mobilization efforts the poor tend to individualize the goals of the struggle. The possibility and vision of a classless and non-exploitative social order is obscured by their submersion within the existing order.

To be more concrete, Rakku sees her struggle in a personal way. Yet behind her personal struggle there is a basic, though unspoken, awareness of her predicament as a common one within the labouring part of her community. She knows the distinction between families whose children are strong and healthy, and families like her own whose children generally are not. But her awareness remains unexpressed. The process of consciousness-raising brings together the many Rakkus in a way which makes possible the expression and critical analysis of their individual struggles. It enables them, through mutual support, to speak out, but as well channels such experience into a critical understanding of the source of their common

predicament. Most important, it makes possible collective action to challenge the exploitative power structures in their community and beyond.

This analysis will not attempt to consider the process of consciousness-raising in the depth it deserves, but instead refers the reader to some studies of popular movements throughout the country.²⁰ It is unfortunate however, that detailed recording of many popular movements in India is limited — a reflection of the difficulty and consuming nature of such action. Though the term consciousness-raising (particularly "conscientization") is most often associated with the writing of Freire, it refers to a process which has been a part of at least some of the political mass movements in India in this century.

We have briefly considered the process of consciousness-raising and organizing to explore the possibilities of authentic health involvement, but also to highlight the implications of such involvement. For to talk about social action at all carries the further obligation to acknowledge the arduous and extended nature of such action, as well as the risks. Resistance should be expected both from outside the communities — most obviously from threatened interests in the health and political professions — and more directly from those in the communities whose interests will be threatened by the increasing consciousness and strength of the poor. Unless those involved are prepared for and skilled in dealing with the inevitable tensions, the process is likely to overwhelm and intimidate. Thus the need for basic training is as important for the committed health worker as it is for the literacy worker or the labour organizer. Unfortunately it is often the "professional" health worker who is *least* prepared, culturally and ideologically, for this work. Therefore there is an even greater need for acquiring skills and analytic methods.

4. Social Action: The Broader Framework

To contribute to societal change, organizing efforts must be linked with similar struggles within a broader movement. Without trying to prescribe a specific "course of action" for the socially-committed health worker, it is possible to suggest here a general framework for progressive health action by asking three basic questions:

- i. Does the health action increasingly enable the labouring poor to expect, demand and obtain the health care services which the government professes to be their right?
- ii. Do the health activities concretely address the economic roots of ill-health?

- iii. Does the local health action contribute in a concrete way to change in society? That is, does it strengthen the labouring/working class movement in India?

The first question leads to the issue of social accountability; and the second and third, to the need for grounding health action within a broader mass-based political movement.

Accountability in the Health System

What is meant by social accountability? Officially, the Indian government has committed itself to establishing basic health services for all the people. This is clearly stated in the Constitution, and the public urban hospitals and rural health centres (although maldistributed) attest to this policy commitment. Yet there is no real possibility for Rakku to *insist* on basic care from this health system (assuming of course that she had the income and time required to seek such care). Whether she receives rehydration treatment for her child at the PHC — which she most likely would not have, had she taken the child there — or at the District hospital, is something entirely out of her control. It happens that this care was given at the city hospital. The point is, however, that had she not received this care, she would have been powerless — emotionally, socially, politically, and economically — to insist otherwise. In other words, the health system is neither responsible nor accountable to Rakku.

This can be seen even more readily with regard to rural health services. As a labouring, low caste and illiterate woman Rakku cannot insist that primary health services, offered in theory, be made available to her family. Or that the PHC doctor be on duty at times when she could realistically reach the health centre. This lack of accountability maintains her in a remarkably dependent position relative to those who shape and control health resources nationally.

How, then, does the system work? What propels its functioning? Official development strategy has been to foster the implementation of specific programmes solely from above, that is, through its administrative machinery. Little consideration is given to building up consciousness among the "beneficiary" — masses to ensure implementation from below. In fact, it appears the government avoids developing public consciousness for accountability. One wonders why? Are the labouring people incapable of judging what is in their collective best interests? The distribution of development benefits, such as wheelchairs to random polio victims or free textbooks to scheduled caste children, may or may not be real benefits to individual

poor. But in hoping to receive benefits, real or token, the poor are led to adopt an even more passive posture towards those in power. Yet is there any reason why the government could not, at the same time, encourage awareness of their *right* to, say, educational assistance (since such a small proportion of education funding benefits the labouring classes anyway)? Or their *right* to polio immunization? On the contrary, even the simplest of consciousness-raising efforts is carefully avoided.

If we stop to consider what social accountability means, we may begin to understand why it is not given much attention, either by the government or most development agencies.²¹ That government bodies might in any way be accountable to the labouring majority implies a relationship between the poor and the ruling class profoundly different from that which now exists. It also implies a consciousness within the people of basic human rights, and a capacity among the poor to organize to establish and protect those rights. Yet the very term "right" pre-supposes a consciousness of *self-worth*. As we have seen, behind such a consciousness must lie a radical re-evaluation of their own labour, not according to prescribed caste notions, but rather according to its real (economic) value to society. This demands a rejection of the traditional hierarchical notions of labour and human value.

For example, to demand accountability from the health system—perhaps in her case to insist on longer treatment for her child—Rakku must *know* that her child has as much "right" to treatment, and therefore to life, as any other child. She must believe that her child embodies as much "worth" as another.

Yet even if Rakku did clearly, and one might add fearlessly, believe in the right of her child to live, could she as a single individual hope to influence the government health services either at the PHC in her Block, or at the district hospital, to provide "equal" care to her child? (This does not imply the most technically advanced care available, but simply equal care and attention to what is possible for all children in India)... Not at all, unless there were some substantial degree of organization among the many similarly poor families. On her own, protest would be pitifully ineffective.

Limits to Local Organization

Let us take the argument one further step. If the poor in a few villages were to organize to protest against inadequate PHC services, there might be some kind of *local* official response. Paramedical

workers might visit the villages earlier and more regularly, an indifferent medical officer might be transferred, more regular supplies of vaccines or TB medicines might be forthcoming, at least temporarily. Yet is it not likely that such local protest would in fact only mean the diversion of medicines from some other area, and the transferring of the medical officer to another PHC? Is it therefore realistic to expect that political pressure by the poor in one local area could lead to accountability within the health system as a whole—let alone to a fundamental re-shaping of the system?

Could we expect, for example, that all the Rakkus in her village or indeed Block, could exert enough pressure to bring health officials to extend the hours of the morning Out-Patient clinics, so that villagers could reach them in time? Could they, on their own, force the government to produce and make available sufficient INH and Streptomycin for all TB patients in the country? Could Rakku, by organizing the labouring women in her area, achieve a redistribution of health resources and workers, a redistribution based on need, rather than on the interests of the medical profession and urban elite? And finally, since the roots of ill-health are economic, could the labouring families from a single village or group of villages pressure the government to raise the minimum wage (or even enforce the existing minimum) let alone redistribute land to those who labour on it? Clearly not. Such substantial changes can only come about when Rakku and all those whom she represents are organized together in a broader movement. Local efforts must be part of a larger process.

But there is also a very pragmatic reason for linking local efforts to a broader movement: for it is unlikely that single communities can successfully organize on their own. Indeed, the risks associated with such organizing can make isolated efforts in effect irresponsible. Thus, local organizations must be linked to, draw strength from and give strength to, a broader organization and framework for action—that is, a mass movement.

The Need for a Political Commitment

The activist health worker thus faces a political commitment. Our purpose here is not to suggest how local organization can be linked with a broader organization. For such broader structures can only be developed by the people themselves in the process of their growing consciousness and organization. But at a general level, the need for a political movement as an instrument for the transformation of society is undeniable. And clearly, within its activities, such a movement must develop specific policies concerning health care.

Likewise, it is not necessary to identify here specific political movements and organizations through which socially-committed health activists could act.²² Examples are apparent. The questions the health worker as activist faces are: In what ways can his action contribute to such a broader political process? And further, in what ways can his political stand and specific insights into ill-health contribute to consciousness-raising at the local level, and at the broader level, to a strengthening and uniting of progressive forces within the country? As Qadeer suggests, "The primary concern of those who are interested in exploring this potential (of health action) should be to identify political organizations and movements representing working class interests. They should evolve the content of their alternative within the larger social context and be able to show how the liberal and radical components (both pragmatic and human) of their alternative can be made use of for advancing the working class movement."²³

Equally as important, *in what ways can the health worker help to ensure that the people take part in defining specific health care policies within the political movement, and at the same time, that they gain genuine control over such activities?*

We began this chapter by saying that it was not an attempt to suggest a formula for action, but rather to consider in broad terms how health action can contribute to the national struggle for health and socio-economic justice. The thoughts and concepts discussed in these pages are not new. What is perhaps unusual is the direct linking of specific health issues with socio-political questions. The issues raised here acknowledge the political nature of health and health care, and are offered as possible tools for social health analysis and action.

NOTES

1. For example, the Madurai Village Worker Project was able to reduce mortality in children under five years by 60% with a recurring budget of Rs. 2 per person per year for a population of 30,000.
2. For references to this on-going debate, see footnote 8, chapter one.
3. 1978, op. cit., p. 1323.
4. Ibid, p. 1322.
5. 1981, op. cit., p. 1241.
6. 1982, op. cit., p. 203.
7. See for example, Banerji (1981), op. cit., p. 1579, and Paranjape (1981), op. cit., p. 1470.
8. 1978, op. cit., p. 1384.

9. To be fair, Sukhatme's stated purpose for his re-definition of undernutrition is to rationalize government "intervention" programmes. Yet Paranjape points out, "there is no reason why ameliorative programmes should not be so devised as to give priority to the more poor. The use of a particular level of nutrition has nothing to do with the priorities to be observed in programmes relating to nutrition" (op. cit., p. 1472; emphasis added).
10. 1978, op. cit., p. 1384.
11. See *Poverty, Class and Health Culture*, op. cit.
12. Yet this basic position crops up in each of his replies within the debate. For example, he later justifies his position by pointing out that physically smaller women in a slum make-work project produce as many (or more!) chapattis as those with larger body size (1982, op. cit.).
13. Sukhatme writes: "Already our work has aroused widespread interest among economists, statisticians, social scientists, nutritionists and medical doctors. It has also aroused interest in the Planning Commission, the ICMR, the Indian Council of Agricultural Research, ICSSR and in the Department of Science & Technology. At their instance we recently held two institutes... to acquaint senior scientific workers with the newer concepts in nutrition and their implications for policy and planning" (1981, op. cit., p. 1323).
14. A.R. Kamat, "Struggle For New Society: Ideas and Values — Post 1947 Contradictions", *Mainstream*, May 2, 1981.
15. For a good example of such an analysis, see Abhay Bang, "Cost of Production of Labour and Minimum Wage", *HOW*, July & Aug. 1981, p. 5.
16. See the example of Chile, above, footnote 3, chapter four.
17. S. Kaithathara, D.C. Mariam, "Community Health to Build Up People's Leadership: The Berhampur Experience", in W. Fernandes, 1981, op. cit., p. 125; S. Kaithathara, "Community Participation in Primary Health Care", *Social Action*, July-Sept., 1981, p. 351; and I. Qadeer, "People's Participation in Health Services", *Medico Friend Circle Bulletin*, Nov. 1977.
18. S. Martine, "Harijans Can Act: An Experiment in Liberating Education", in Fernandes, op. cit., p. 72.
19. Western development agencies have tended to distort Freire's original work for their own purposes (often the promotion of Family Planning). This distortion can lead to the manipulation of the poor and subtly diverts their "attention away from the political and economic causes of social and personal problems" (cf. R. Kidd, K. Kumar, "Co-Opting Freire: A Critical Analysis of Pseudo-Freirian Adult Education", *EPW*, Jan. 3-10, 1981).
20. For references, see the "Selected Bibliography", part 3; G. Omvedt, *We Will Smash This Prison!*, Orient Longman, 1979; "The Story of Shramik Sangathan", *HOW*, June 1978, pp. 24-8; and the forthcoming CSA booklet on "Mass Education and Conscientization".
21. The presumed accountability represented by the ballot box deserves comment. The distance between the ruling class and the labouring villager is so great now that a good dose of moneyed electoral campaigning can quite well obscure specific political issues, and therefore the possibility of accountability through the electoral process.
22. The unquestionable need for linkage of local action with a political framework raises

other questions — questions which might be used to justify avoiding broader political involvement. The on-going debate and disunity among progressive groups committed to radical structural change is such an example. This book does not claim to give solutions to such questions — but only asserts that the need for political involvement *also* implies the obligation to contribute to the resolving of such questions as they inevitably arise.

23. I. Qadeer, "Limitations of Another Development in Health", *Social Scientist*, Feb. 1980, p. 36.

Conclusion

The Source of Ill-Health

This is a book about people in India who yet live in ill-health. Our analysis has looked beyond the medical labels for causes of death and illness. It instead looks at the reasons why preventable deaths fail to be prevented, why simple illnesses fail to be treated. Acknowledging the vast and increasing medical expertise in the country, it has explored the contradictions within society which prevent these resources from effectively solving the problems of ill-health. Above all, it has considered how the absolute prerequisite of health — access to adequate food — continues to be denied to the common people. It thus has sought to expose the *source* of continuing ill-health.

In this search, this study has grounded the problem within the day-to-day reality of those who bear most heavily the ill-health burden. Rakku's story has progressively led to questions which explore interests, forces and powers throughout society — the relationship of her life, and of *her own and her family's labour which sustains it*, within the social order. I have chosen to pursue these questions, though broad, because of the surprising dearth of concrete analysis as to *why* the poor majority continue to remain "out of reach" of official health care efforts. In looking at Rakku's life, I do not suggest that her story is necessarily typical. But in following her journey, the more general barriers which she confronts — indebted poverty, the structuring and distribution of health services, and above all, the concrete unimportance of her child's life within the socio-economic structure of society — emerge as *common* barriers which lie at the heart of many, perhaps most, of the millions of unnecessary deaths each year.

Each step of the analysis and Rakku's journey raises specific questions. It is up to the reader to decide how directly these questions relate to the labouring families of her specific region of the country. Some of the questions confronted include the following:

1. Why does Rakku delay in taking her child for care? To what degree is her delay due to traditional beliefs? To what degree is it due to poverty?

2. Why are her children malnourished? Are traditional beliefs or poverty the over-riding cause?
3. In a State with perhaps several thousand unemployed doctors, why does the Out-Patient department of the district hospital close by mid-morning?
4. Who ultimately pays to train the country's doctors? Who benefits from this training, and who does not?
5. Why is ill-health tolerated by the poor? What determines the unimportance of Rakku's child?
6. How can Rakku ensure that in future her children will not die needlessly?

In seeking answers, one discovers that ill-health is inextricably linked to the entire socio-economic system. Therefore, rather than being simply "unfortunate", the on-going situation of ill-health is a *predictable* outcome. Dramatic maldistribution of food, as well as of doctors and health funding does not occur by accident, but is a predictable result of market laws and class interests. The difference in child mortality between classes is so great not by chance but because of the particular distribution of *all* resources in society.

In seeking a solution to ill-health, this broader relationship must be addressed: that is, the link between Rakku's mud hut and labouring existence and the entire structure of society in which it is located. Only then can there be realistic suggestions as to how the poverty — dependency — ill-health cycle can be interrupted. Is it reasonable, for example, to assume that the cycle could be broken simply by exhorting young doctors to go to the villages? Or by inserting more nutrition education into the training programmes of health workers? Or even by posting a Community Health Worker in every village? Clearly not. Such efforts can only be attempts at treating *symptoms*, no matter how well-intended — and no matter how useful each of these initiatives might be when placed within a radically different socio-economic system. Likewise, while it is important to understand how the medical profession benefits from the existing organization and distribution of health resources, it is simply not enough to blame the profession for existing health disparities. Or for that matter, to blame the transnational drug companies. Their role in distorting many aspects of the health care system in India is real; but it is a role which the social order in India defines for them. For example, would nationalization of all foreign drug companies fundamentally alter the ill-health cycle? (In stressing the inadequacy of this as a *solution* to ill-health, it is not suggested that such a measure is necessarily undesirable.)

In taking the broader perspective into account, answers to basic questions begin to emerge. One can, for example, begin to understand why infant mortality or TB death rates have remained virtually unchanged over the past several decades. They remain unchanged because the more fundamental causes of childhood death, poverty and dependency, have also remained unaltered. In spite of often remarkable technical achievements and the expansion of health institutions (increasing numbers of PHCs, "package programmes", and rural schemes) the *source* of ill-health — the economic and social structures, which reflect unequal and exploitative relationships between classes in society, continue to maintain and churn out low productivity and poverty, hunger and powerlessness, and so, ill-health as well. For just as the official rural health system holds little significance for the majority of rural families, so too for the official economic strategies. Minimum wage legislation, security of tenancy, abolition of debts and bonded labour, land redistribution, and so on, often have little meaning for the rural poor, precisely because they are so poor and economically vulnerable. As individuals they cannot afford the risks involved in struggling to have this legislation implemented. Nor can their efforts match the power of those who resist implementation.

At the individual level "dependency" refers to an unequal relationship of power — a relationship in which the labour and life of one person is controlled in varying degrees by another. Dependency is the key factor that allows the poverty — ill-health cycle to continue. It is thus the single link in the cycle through which authentic change is possible. Only organizing by the labouring poor can challenge such control over their labour and lives.

In this sense, it is revealing to consider the framework of official development/health activities. Phrases such as "health *delivery* system", "*provision* of basic needs" (as opposed to basic rights), and "*uplift* of the poor", betray their pacifying and paternalistic nature — an approach which assures that the existing distribution of powers in society is maintained, an approach which offers little that would allow the poor to collectively extract themselves from their dependent position in society. One wonders how much government interest would be forthcoming for schemes which instead sought to "organize for basic rights", and encouraged "standing up by the poor"; or for programmes to establish genuine accountability to the poor for even the existing health services. Can it be considered accidental that the concept of accountability is absent from government planning — and the activities of most voluntary agencies?

But is such a 'radical' approach to ill-health really necessary? For some, this analysis will seem unnecessarily provocative, and inappropriate to address to health workers. After all, Rakku still received care for her child. And so do many thousands, literally hundreds of thousands of other children. And this is so, compared to two or three generations ago when there was little such care available to the masses. Indeed, one needs only walk through the rehydration wards in many urban government hospitals to be deeply impressed with the number of children being saved each day through such institutions. Yet it is equally true that the majority of such village children never reach this kind of care. And that even when they do, many are too malnourished to be saved with the best of modern techniques, or succumb soon after discharge, as did Rakku's child, from underlying malnutrition which re-invites disease.

There are a number of reasons, then, for presenting such a broad, or radical analysis of ill-health. The first is perhaps the most obvious: the limits and even impasse which the "medical model" approach faces in India. Infant mortality for the rural four-fifths of India's people has not substantially improved in over a decade, and in fact has shown relatively minor improvement since the 1950s. Class differences continue to be enormous; indeed, disparities in health status between the middle and affluent classes versus the rural and urban poor are widening.¹ At the same time, the proportion of the population living below poverty line appears, if anything, to be increasing. All this is so in spite of two decades of anti-poverty strategies, Green Revolutions and massive nutrition and health schemes. Is it therefore inappropriate to conclude that the questions so far raised have been inadequate, and that deeper analysis involving economic and political issues can no longer be avoided? Indeed, there are many progressive political workers and activists who would quite correctly say that these deeper questions should never have been avoided in the first place — that is, from Independence and even earlier. Perhaps the most important question then that this analysis can raise is why and how the obvious source of ill-health, that is, poverty, lack of access, to minimally adequate food and maldistribution of all resources, has been effectively side-lined from the consciousness of the health establishment and the people.

This leads to a second reason for such an analysis. There is yet very little systematic grappling with the contradictions inherent in the health system as a whole. Token lamenting over "symptoms" has just begun to be heard. But these admissions often stop short of deeper

exploration of the societal roots of the problem. Why is it, for example, that available health resources are distributed in the way that they are? And what does that distribution reflect about the social structure itself? What allows ill-health to be tolerated within the socio-economic order?

What is worse, there is at present a remarkable tendency for health analysis efforts to get caught up with tangential and apolitical distractions. Superficial concepts which are now quite fashionable with the elite in Western countries, such as "holistic" and "life-style" medicine, and a somewhat naive emphasis on "self-help" care, are appearing in health seminars and treatises in India as well. While such notions may be of some relevance to the elite in the country (just as they are to the more affluent sections in the Western societies), such a focus becomes ludicrous in the face of the leading causes of death in Indian society — malnutrition, diarrheal dehydration and tuberculosis. Surely it is nothing less than obscene to be discussing herbal medicines, yoga and "life-style" changes, when the tuberculous lungs, grossly inadequate diet and excessive labour demands are rapidly depriving the agricultural labourer or quarry worker of any life at all.²

At the same time, the author has been left with the uncomfortable feeling that the current interest in traditional and herbal medicines can very easily lead, under the banner of "self-reliance", to a justification of two levels of health care within society. While a number of health projects in India have sincerely attempted to study and promote herbal medicines, project organizers are often the first to reach for allopathic medicines for even minor illnesses in their own families. This is not to suggest that they should not do so, but rather to stress that *the right for the poor to be able to freely chose is equally as legitimate.*

Nor do I mean to denigrate the role and benefits of traditional remedies and systems of medicine; but rather, to point out that just as for allopathic curative care, they cannot be expected to solve the ill-health problem because they do not touch its roots. In their health analysis of a Tamil Nadu village, Djurfeldt and Lindberg reached a similar conclusion. While recognizing the real benefits and continuing popularity of traditional health methods and healers (often due to the economic and cultural inaccessibility of modern practitioners), they critically highlight the limitations of *both* systems of medicine in being able to significantly alter the rural ill-health picture. They conclude that "indigenous medicine is definitely capable of improving the *medical care* available to the Indian people. But it cannot do very much to

improve their *health* situation."³ This distinction is crucial. But unfortunately, in the clamour for easy answers and fashionable development concepts, it is often over-looked or even ignored.

The final reason for attempting a broad analysis lies in the yet unappreciated dangers which the current "primary health care" thrust potentially represents for the poor. Introducing local health workers into rural communities through (that is, paid and supervised by) external government agencies is likely to have two results. First, there will be little significant change in health status, especially for the labouring families. For such schemes cannot encompass acute life-saving care; nor the massive educational work economic transformation and political structural change to prevent continuing monopolization of services by the economically dominant. And the second result will be that whatever symptomatic services the Community Health Worker can provide will only tend to add to the dependency of the poor. Thus, the dependency-creating effects of the scheme, as with the activities of the international agencies, are likely to outweigh any genuine health benefit.

Let us, for example, consider the Community Health Scheme. Given that in most villages power remains in the hands of the traditionally and economically dominant groups, what is the possibility of such a scheme contributing to develop accountability of government structures to the health-less? Or contributing to develop an awareness among the poor of their health rights? Or is it not much more realistic to admit that such village health services are likely to become another "development" activity which will be used by local power groups and politicians to increase their dominance within the community? The entrance of party politics and election campaigns in many Third World societies has often had the result of actually strengthening the patronage system. As Huizar observes: "Since political functions for which the election campaigns are held generally imply that the local elite get certain government resources at its disposal or under its influence or direct control, such as funds for roads, schools, *medical and health services*, etc., these resources can be utilized in addition to the traditional ones of land and power to keep peasants in dependency... (Thus) promises of official help are used to keep peasants in conformity."⁴

It is in this sense that such primary health care schemes can become instruments for increasing social control over the poor. Such programmes introduce benefits which will bring about, at best, a token change in health status. Yet at the same time, they create even greater

dependency by leading the poor to hope for some benefits and "extend their trembling hands". Hence, they tend to push further away from their consciousness the idea of social/political accountability — the idea of their basic human rights and worth, and their collective capacity to realize those rights and achieve social justice.

Furthermore, since the CHW's first obligation cannot be to the common villager, but to those who pay his salary, key issues such as low wages, land distribution, and so on, can hardly be addressed, and in fact, may very well be opposed by him. And so the dependency cycle is strengthened.

Throughout this analysis we have attempted to distinguish between two very different approaches to the problem of ill-health. That is, a socio-economic analysis, leading to political action, on the one hand; and on the other, the current and fashionable enthusiasm for primary health care delivery. Such a distinction may seem inappropriate. Yet the framework of action to which each approach naturally leads are diametric opposites. This is because each is based on an entirely different interpretation of the nature and source of ill-health. Whereas the provision-of-basic-needs approach posits *lack or absence* of specific ingredients (technical, organizational, informational or attitudinal) as the source of the problem, the socio-political interpretation looks at the *presence* of particular factors — oppressive economic structures, dependency, and as symptoms of these forces, hunger and powerlessness — as the primary cause of societal ill-health. Such differing interpretations reflect an individual versus a societal perspective. And most importantly, the proposed solutions which naturally flow from these differing "diagnoses" come to have a humanly *domesticating* effect as opposed to a humanly *liberating* one.

This is not to suggest that the political approach *excludes* specific technical "ingredients". Clearly, scientific information, and specific vaccines for example, are essential tools to which the people have a right of access, and a right to control collectively. Yet these "tools" in themselves are insufficient for transforming health status. In the immediate day-to-day struggle of health and disease, life and death, these theoretical considerations may seem an extravagance. Yet they are not, precisely because efforts that remain at the technical level cannot be expected to succeed in "curing" the problem. And at the political level are likely to make the dependency source even worse.

The Source of change

We have come full circle. We began this study of ill-health at the

doorstep of a single village woman, tracing the barriers she confronts in trying to save the life of one of her children. The many questions raised by this child's death have led step by step from Rakku's village home to the structures of Indian society as a whole. Yet ultimately even within this broader perspective, the questions raised bring us back to the life of this particular woman — though now in relation to the rest of society; that is, looking at how Rakku's economic and cultural dependency entirely shapes and limits the possibilities for adequate health for her family.

Linking the broadest structural problem back to this woman makes it possible to discover what type of action has meaning within the overall struggle for health change. Rakku herself and the millions of similar women and men she represents must truly and concretely be the focus and source of such action for change. For it seems clear that ill-health, malnutrition, poverty and dependency will continue no matter what "package", "community-participated" schemes exist, until the labouring majority THEMSELVES insist that it must be otherwise. And for the poor to be able to insist effectively requires political organization.

If, in the final analysis, social transformation requires a rejection by the poor of previously accepted values of social and economic inequality, then such change will necessarily involve tensions arising from interests which are thereby challenged. To ignore and avoid such tensions is only to oppose and postpone true change, and perhaps to invite even greater tensions and upheaval as the historical process of social change progresses. Thus, if the challenges involved in the struggle for human rights, including health rights, are ignored through superficial and inadequate theory for action, an even greater disservice is done not only to the millions of Rakkus each year but also to Indian society as a whole.

The question the individual health worker faces is whether he or she wants to be included within the progressive effort already in process in the country; that is, wants to be involved in using her or his particular technical knowledge to raise questions and support action by the poor which would fundamentally transform the existing social, economic, political and health order. The health worker must decide whether to join the labourer and peasant in a common struggle for radical social change. Or whether, in the charitable and therefore "safe" posture, to stand above them, distributing the largesse of health services, "alternative" or otherwise.

NOTES

1. See above, p. 65.
2. For a critical analysis of the inadequacy, even in the industrialized countries, of the "life-style" approach to health care, see Navarro's "The Industrialization of Fetishism: A Critique of Ivan Illich", in *Medicine Under Capitalism*, op. cit., pp. 103-31.
3. *Pills Against Poverty*, op. cit., p. 216.
4. G. Huizar, "Peasant Organization Strategies and Counter Forces", *HOW*, Jan. 1981, p. 11; emphasis added.

Appendices

I. Estimating Mortality in Young Children

The recent study of child mortality by the Government of India¹ has given the following mortality rates for children under five years of age:

	Rural	Urban	Total
Infant Mortality (0-12 months)	136	70	125
Under Five Mortality (0-5 years)	192	101	174*

These statistics reveal that 174 out of every 1000 children in India die before their fifth birthday. On the basis of the 1981 census figures for birth rate and population,² these rates indicate 4.5 million under five deaths each year. Accuracy of the Sample Registration Surveys (SRS) has improved significantly over the past several decades; yet even these rates may under-estimate infant and childhood mortality to some degree, especially in the rural areas. This conclusion is suggested by a number of smaller studies which observe child survival in particular villages over a period of time rather than through intermittent survey visits.

For example, the 1969-70 Gandhigram study referred to in chapter two³ found considerably higher infant mortality rates than the SRS data, varying from 141 in the higher castes to 219 in the lowest. SRS data for the same period showed rural infant mortality in Tamil Nadu to be 112.5.

In reviewing child mortality studies, Mandelbaum also points out that "higher rates are reported from close studies of particular villages. Thus mothers in six villages of Delhi State had lost about 36% of their children within one year of birth.⁴ In a village near Meerut, U.P., mothers under the age of 30 had already lost 38% of their live born children".⁵ Likewise, Marshall found infant mortality in a U.P. village

* This figure is not given in the report, but can be calculated on the basis of data from Statement 55, p. 35.

in 1968-69 to be 321, "more than twice that alleged for India as a nation". "Women between the ages of 20 and 24 averaged 1.6 births but only 0.8 surviving children: women between 30 to 34 averaged 6.6 births with 3.6 living children".⁶ More recent data (1979) from Ramnad District, Tamil Nadu, suggested an infant mortality rate of 175.⁷

Results from local studies such as these can hardly be generalized to the country as a whole. Yet they do suggest the possibility that overall mortality in rural children under five years may be as high as 25%; that is, 250 deaths per 1000 children live born.

One explanation for the higher rates recorded by studies in which researchers are regularly present in the communities is that data from the poorest families are perhaps less likely to be "missed". From personal experience over the years in rural Tamil Nadu, the poorer labouring families were often the most difficult to contact. For it was precisely these parents who had to leave their homes early in the day for field work. Indeed, some of the most destitute families would be forced to leave the village for varying periods in search of work as migrant labourers. In contrast, it was unusual not to find at least some adults at home in the wealthier landowning households. In this sense, there may be some degree of bias in the larger state-wide or national surveys where vital events cannot be recorded on a continuous basis. To what degree this might create a consistent bias in data recording is difficult to say. Unfortunately, there are few studies which have rigorously analysed the class profile of households "missed" in the samples randomly selected for survey.

The above studies reflect the impression one gets in most villages: the majority of families, even today, lose at least one child, and not uncommonly two or more. Indeed, Banerji found that almost 8% of rural families had lost four or more(!) children. Thus, this analysis suggests a figure of five million childhood deaths each year, one that is slightly higher than the 4.5 million calculated from the official (SRS) data; but even at this, perhaps an under-estimate.

NOTES

1. *Survey on Infant and Child Mortality, 1979*, Office of the Registrar General, Ministry of Home Affairs, New Delhi.
2. That is, a birth rate of 36.6 per thousand, and a population of approximately 700 million.
3. See chapter two, footnote 16.

4. S.N. Agarwal, *A Demographic Study of Six Urbanizing Villages*, Asia Publishing House, 1970.
5. D. Mandelbaum, *Human Fertility in India*, U. of California Press, 1974, p. 18.
6. J. Marshall, "Some 'Meanings' of Family Planning to an Indian villager", *Research Previews*, U. of North Carolina, vol. 19, 1972, p. 28.
7. Unpublished data, The Madurai Village Health Worker Project.

II. Causes of Death in Underfive Children

Perhaps the most detailed long-term study into causes of death in rural children was carried out by Gorden and Singh in the Punjab between 1957 and 1960, each child death over the period being investigated by a medically trained worker.¹ The recent GOI child mortality study found a strikingly similar profile.² Both studies revealed the same seven leading causes of death in under five children.

Causes of Death in Under Five Children

	Gorden/Singh Punjab Study 1957-60	GOI All India 1978
	%	%
Prematurity/Birth Injuries	21	21
Diarrhea (incl. Dysentery)	21	20
Tetanus	10	9
Pneumonia	7	7
Measles	6	5
Typhoid	4	4
Tuberculosis	3	3

NOTES

1. J. Gorden, S. Singh, "Death Rates and Causes of Death in Eleven Punjab Villages: An Epidemiological Study", *Ind. J. Med. Res.*, 49, July 4, 1961.
2. As calculated from Table 23, op. cit., p. 71.

III. Motives Underlying International Development Aid *

It is no longer any secret that much of the development aid from the industrialized Western countries has been motivated and shaped by economic and political self-interest; that is, the nature and framework of "aid" programmes, rather than representing generous gestures, have to varying degrees been calculated to bring about net benefits to the donating countries. In one sense this is hardly surprising. Yet "development aid" has been consistently garbed in altruistic, charitable terms by Western governments and agencies — in terms such as "Food for Peace", "Green Revolutions" for food self-sufficiency, "provision of basic needs", and so on. In other words, the well-being and benefit of the Third World poor has been made to appear as the prime, even sole, motive behind "aid" activities. It is precisely because of this image of "good-intent" that critical analysis of aid from within recipient countries has been extraordinarily difficult. At the same time, the political naivete and overall ignorance of the structural nature of underdevelopment on the part of the general populations of most Western countries has meant that the aid policies of their governments continue to receive their basically unquestioned support.

Ultior motives underlying development aid reflect political (ideological), economic and military needs of donor countries. This is true for aid from individual countries, termed *bilateral aid*, as well as for assistance from many of the *multilateral* agencies which are dominated by the same countries. It is difficult however to separate these three areas of interest, for economic factors often underlie political and military needs.

These introductory comments require several qualifying remarks. First, the degree to which national self-interests have influenced aid policies varies among Western countries, with the U.S. deservedly receiving the brunt of the criticism. Yet analysis of the aid policies of less powerful Western countries is beginning to reveal similar, though perhaps less heavy-handed, patterns of self-interest. Second, it is clearly recognized that in many cases the immediate technical needs of Third World countries cannot in themselves be disputed. Yet the development of technical infrastructure through assistance programmes — for example, hydro-electric dams, advanced agricultural equipment or specialized medical training — in no way

* This rather lengthy appendix is included because of the still limited nature and availability of critical analysis of foreign aid in India.

guarantees benefits to the poorer majority and often leads to increasing disparities between the local elites and the common people. At the same time the framework within which this technical assistance is offered is often disadvantageous to the recipient country. For example, well over 80% of bilateral aid takes the form of "tied aid" which requires inputs to be bought from the particular donor country — inputs which may be less than appropriate for the aided project, and often more expensive than if purchased on the open market. Third, most development "aid" does not consist of free grants, but are loans which must be repaid, though often at concessional rates.

Finally, this appendix is not intended as an *evaluation* of Western aid as such, for which more thorough documents exist. It is simply an overview of motives and interests behind aid programmes, which examines various policy statements of Western governments and agencies, as well as some recent analyses. It is also not intended as an ideological swipe at Western capitalist countries via their foreign aid efforts, for clearly considerations of self-interest are reflected in the pattern of international assistance from the socialist bloc countries as well. However, it seems appropriate to focus on Western aid in this health analysis because of its *enormous scale and influence in India, and the astonishingly uncritical way in which it continues to be accepted.*

The Overall Strategy

Generally speaking, the underlying goal of development aid from First to Third World countries is one of stabilizing the economic and political relations between these regions. Aid from individual capitalist countries has been shaped to open up and guarantee access to Third World raw materials and labour essential to the economies and corporations of the donor countries, and to develop markets for exports to the Third World. Included in this strategy have been programmes for dumping "burdensome surpluses", particularly of agricultural products or non-competitive commodities. For example, the U.S. economy's increasing dependence on agricultural exports for maintaining its balance of payments has led to massive programmes to promote U.S. agricultural sales in the world, and particularly to the Third World. The opportunity for economic stabilization which development aid represents to industrialized countries has taken on an even greater significance in the face of the global recession of the 1970s. As the president of the Canadian International Development Agency (CIDA) explained in 1977, Canada's sagging export economy "requires that CIDA strive to ensure that its activities maintain or

generate employment and economic benefits to our own country."¹

To ensure acceptance of such economic relationships, Western countries have moreover sought to *stabilize the political structures in the Third World which would be sympathetic to such First World economic needs*. In an official document entitled "Winning the Cold War: The U.S. Ideological Offensive", the Deputy-Director of USAID has clearly stated these objectives: "Our basic, broadest goal is a long range political one. It is not development for the sake of sheer development... An important objective is to open up the maximum opportunity for domestic private initiative and to ensure that foreign private investment, particularly from the U.S. is welcomed and well-treated... The problem is... to evaluate the manner in which the programme can make the greatest contribution to the totality of U.S. interests."²

In order to understand better these politico-economic motives behind international aid, let us briefly trace the historical roots of "development aid". Immediately after World War II, the growth of nationalist movements in the Third World was forcing the dismantling of colonial empires. Western governments keenly felt the need to draw the newly emerging nations away from the socialist development alternative. Carty and Smith, in their analysis of Canadian aid,³ observe how the Colombo Plan (involving the South Asian countries of India, Pakistan, and Sri Lanka) was one of the earliest efforts by the departing British to establish "capitalist economies in Asia". Britain was assisted in this task by Canada, New Zealand and Australia, and later joined by the U.S. and Japan. The authors add that "the Colombo Plan was conceived because Asia was, at the time, the hottest spot in the spreading East-West struggles." Pearson, (later to be Prime Minister), thus reported in 1950 Canada's participation in this Plan: "If South-East and South Asia are not to be conquered by Communism, we of the free and democratic world must demonstrate that it is we and not the Russians (he might have added the Chinese as well) who stand for national liberation and social progress."⁴ Almost thirty years later, the official rationale for Canadian economic assistance to the ASEAN alliance (including Thailand, Indonesia, Malaysia, the Philippines and Singapore) was again explained, this time by the Canadian External Affairs Minister, in terms of it being "the last bulwark against Communism in this part of the world."⁵

What is most interesting about these ideological statements is not so much their questionable judgment about capitalist development leading to "liberation and social progress", but rather, the way in

which they confuse the issue of socialist systems on the one hand, with Soviet influence on the other. Indeed, Western economic leverage and sanctions — including military intervention — against Third World countries which have attempted to build socialist societies, have repeatedly driven independent Third World countries into increasing dependency upon the Soviet Union. It would seem, then, that the anti-Communist rationale for aid has in effect been as much an eye-wash for maintaining First World economic interests and dominance in the Third World, as a strategy for saving poor nations from "the Russians".

Economic Benefits for Donor Countries

It is not simply the extension of business markets and investment into the Third World which is beneficial to the economies of donor countries, but also the *terms* under which such investment is extended. These terms are generally very advantageous to corporations of the industrialized countries. For example: "In 1976, foreign earnings in the Third World by Canadian corporations were \$ 422 million — about 47% of the amount Canada disbursed in aid for the same year. The amount remitted to Canada is about twice as great as the investment capital originally sent to underdeveloped countries. Between 1970 and 1976, for example, Canadian corporations brought home \$ 1,304 million in remitted dividends and interest payments on their foreign investments compared to \$ 666 million sent abroad in direct investment flows during the same period."⁶

If the disparity is so considerable for an economically small country like Canada, how much greater it must be for the large Western nations. Furthermore, while foreign aid accounts for only 7% of all capital available to Third World countries (over 80% comes from domestic savings, and the rest from commercial loans and un-"aided" foreign investment),⁷ the conditions under which such assistance is given tend to influence and shape to an inordinate degree the overall economic structures and policies within the receiving country. For example, the \$ 5 billion IMF loan recently granted to India represents only a small proportion of the country's capital over the three year period of the loan. Yet the IMF terms prescribe significant changes from previous national economic and social policies.

At a perhaps less intentional level, the foreign aid channeled into technical training has produced important benefits to the industrialized countries by the immigration of much 'human capital' into the donor countries. It has been estimated, for example, that the *annual* loss to

Latin America by the flow of doctors to the U.S. is equivalent in value to the total volume of medical aid from the U.S. to Latin America during the entire decade 1960-1970.⁸ Likewise, between 1963 and 1972, Canada admitted 56,000 skilled and professional immigrants from underdeveloped countries. The direct saving to Canada in terms of training costs was estimated at \$ 2.9 billion, while the country's total aid flow to the Third World in the same period was only \$ 2.3 billion.⁹

Why do Third World governments participate in development assistance programmes which are of economic disadvantage to them? Part of the answer lies in necessity: dependence upon the industrialized countries for technological skills and goods, and a similar dependence upon Western-controlled financial institutions. But there is another reason as well. Aid agreements and particular economic programmes offer real benefits to the dominating classes of many Third World countries. Susan George, in her analysis of global hunger and transnational agribusiness activities, describes in detail the calculated schemes, particularly of the US government, which has systematically worked to build up national elites who are "friendly" towards U.S. interests and political ideology. For example, the U.S. Participant Training Programme is a massive USAID-funded scheme explicitly designed to win "the hearts and minds" of future leaders in the Third World. The official "Winning the Cold War" document referred to earlier, explains that this programme "is probably most critical... for the effective communication of ideas... (Trainees) return to their homes to add not only increased skill and competence but whatever they have absorbed of the values of our society... The opportunity for broad social and political orientation exists at every point in the total experience the participant has while in the United States... There are very few countries in the free world where former participants have not had real impact in government, private industry and the professions."¹⁰

Coffen, the USAID official providing these insights, explains how such participants return home, often as members of U.S. professional societies, "to serve as living models of the American approach, not simply to education but to life in general". As the programme so clearly foresees, the prestige and power accruing to the participants by virtue of their Western/U.S. training, gives them enormous influence in local governments and universities, with the ultimate result that their "students tend to organize into professional rather than political societies".¹¹

But it is not only official government agencies which have groomed local elites. George adds: "Part of this bigger and global system (of

'thought control and attitude shaping') is embodied in the private foundations which have (also) been involved in the hearts-and-minds business". The Rockefeller Foundation established medical colleges in China in the early part of this century, "dress rehearsals", George suggests, "for the Rockefeller-financed All India Institute of Medical Sciences founded in 1956." Throughout the preceding health analysis, we repeatedly confronted the inherent inadequacy of purely technical solutions to social problems such as ill-health. There is little doubt that the persistence of such approaches is in great part due to ideologically-imbued Western training programmes.

Of even greater significance, "in case these countries, in spite of so much U.S. effort on their behalf, might still express discontent of a 'violent' or even of a 'political' nature, the U.S. Department of Defense maintains a much larger Participant Training Programme (28,000-30,000 people invited yearly, compared to USAID's 6,000) for UDC (underdeveloped countries) military and police forces".¹² The role of such militarily-trained local elites as back-up to the professionals is clearly evident in such countries as Indonesia, El Salvador, Chile and Guatemala, to name only a few.

As grim as the results of such "training" aid often are, the point of this overview is to compare the publically-advanced motives of charitable "good-intent" of such programmes, with their underlying political motives — motives which are hidden not only from the population of Third World recipient countries, but from the general populations of the donor countries as well.

An Example: Food Aid

A clear example of ulterior motives underlying foreign assistance is seen in the U.S. "Food for Peace" programme. I have chosen to examine this programme more closely, partly because of the large scale to which India has been involved as a recipient, and partly because of the on-going political and economic implications of the scheme throughout the Third World. A blunt but appropriate overview of the programme is given by Carty and Smith and is worth quoting here at length. They write:

"Shortly after World War I, soon-to-be-president Herbert Hoover directed a food relief program developed to support anti-communist movements in eastern Europe. Food aid, reasoned Hoover, could effectively combat the spread of communism at a far lower price than costly military invasions. A quarter of a century later the practice and thinking were much the same. In the aftermath of World War II, Washington shipped large quantities of foodstuffs to fascist forces in Greece, to Chiang Kai-shek fighting Mao's

liberation army in China, and to Italy and France in an effort to woo voters away from their increasingly leftward tendencies and to undercut trade union militancy. "Food is a vital factor in our foreign policy," explained Secretary of State George Marshall...

In 1951, India's request for US grain to stave off famine alerted Washington to new uses for food aid. The US agreed to India's emergency request on the condition that it relax its embargo on the export of thorium, an element essential to American nuclear energy production. India capitulated and the US grain was shipped.

Washington formalized its ad hoc food giving with the 1954 passage of the Agricultural Trade Development Assistance Act, more commonly known as PL480. With barely a mention of altruistic goals, the act commandeered food aid for the service of American "national security" objectives. It would be used to secure supplies of strategic raw materials. It would dispose of price-depressing surpluses of American food products and keep farm incomes and agribusiness profits high and stable. It would expand US agricultural trade, create new markets and function as a vehicle for the pursuit of political objectives. Despite its avowedly self-serving goals, the PL480 program was deceitfully dubbed "Food for Peace"

Since its inception, PL480 has sold or donated over \$25 billion worth of US food products. By offering concessional food aid to its allies, denying it to "unfriendly" governments, and threatening poor non-aligned nations with a boycott if they behaved badly, Washington has wielded PL480 as an effective foreign policy tool to keep nations and regions within the US sphere of influence. As Hubert Humphrey explained in 1957: "if you are looking for a way to get people to lean on you and to be dependent on you, in terms of their cooperation with you, it seems to me that food dependence would be terrific."

Food dependence means using food as a weapon. In 1974, for example, the United States told Bangladesh that it would not be eligible for any more food aid until it stopped exporting locally-made gunny sacks to Cuba. Suffering one of its worst famines, Bangladesh succumbed, cut its Cuba ties and "qualified". When Chile elected a socialist government in 1970, Washington cut off its traditional food transfer program. It even refused to accept hard cash from Chile for food. But after the military mounted a bloody coup d'etat in 1973, food-laden ships immediately set out to aid the new right-wing regime of General Pinochet. By 1975, Chile's junta was receiving more food aid than the rest of Latin America combined.

The deployment of food aid in Vietnam shows its military applications. In 1973, almost half of all PL480 food went to Cambodia (now Kampuchea) and South Vietnam. The latter received twenty times more than the five African countries most seriously affected by drought... Part of the PL480 program allowed the regime in South Vietnam to resell food aid locally and use the funds for other expenditures, including military hardware... So goes

the transformation of butter into bullets. Between 1946 and 1975, the resale of US food aid in the Third World contributed a whopping \$6 billion in local currencies to the military ambitions of consistently repressive and elitist governments."¹³

As hard hitting as this summary may seem, other analyses of the Food for Peace programme reach very similar conclusions. For example, Lappe points out that local sales of U.S. food in Bangladesh contribute almost one fifth of the entire military government's budget, with most of the food going to middle and elite classes and the military.¹⁴ In this way, Third World governments "friendly" to US and Western interests have managed to avoid structural changes in their own countries, particularly changes in land tenure, which alone could allow adequate development of agricultural production to ensure future food self-sufficiency.

Within this analysis several facts deserve emphasis. First, although the U.S. "Food Aid" programme has consistently been promoted as "charity", only a small fraction, one fifth, of the total food shipments, have in fact been donations; the remaining four-fifths have been sold to Third World governments. As a former U.S. Secretary of Agriculture explained: "I think the Food for Peace programme was started primarily as a means of disposing of our surplus stocks. We called it Food for Peace because that was a convenient way to sell it politically in this country."¹⁵

Second, although this U.S. programme represents the bulk of the food sales to the Third World, many other countries including Canada and those of the European Economic Community have also been participants in transferring "burdensome food surpluses" to the Third World under the label of "development aid", though in most cases, political leverage and direct military goals have been much less evident than in the U.S. programme.

Finally, the relationship between food "donations" and the development of U.S. agribusiness markets in the Third World is intimate. An official PL480 document states that "the increase in commercial sales (of U.S. food produce) is attributable in significant part to increased familiarity with our products through the concessional sales and donations programmes." And as Senator McGovern pointed out in 1964: "the great food markets of the future are the very areas where vast numbers of people are learning through Food for Peace to eat American produce."¹⁶ George goes on to explain how concerted strategies to increase markets for U.S. food "are largely carried out through the skillful use of 'counterpart funds' " — the massive cash

receipts generated by food sales which are deposited in U.S. accounts in the recipient countries to be used at the discretion of the U.S. government. These uses include "loans to U.S. companies who want to set up abroad... counterpart funds (being) used to defray all their costs such as land and labour for factory building".¹⁷

George goes on to examine other uses of counterpart funds:

"PL480 has also been one of the major promoters of the Green Revolution. In 1966... the (PL480) law added a certain number of provisions known as "self-help measures", to which recipient country governments were obliged to commit themselves... These measures include in all cases "creating a favourable environment for private enterprise and investment", and "development of the agricultural chemical, farm machinery equipment... industries"... as well as programmes to control population growth... Local currency counterpart funds accumulated by the US in almost all the aided countries far surpass the budget at the disposal of the country's own Ministry of Agriculture. India has been the biggest recipient of both Title I and Title II aid. She has also been the "beneficiary" of half the total loans to the private sector. It is thus not surprising that India's agriculture policy has been largely determined by US foundations, universities and corporations and by the US government."¹⁸

The power and influence wielded by the U.S. government through its Food Aid programme thus affects not only the foreign policy of recipient countries, but as well, their internal economic and social policies.

Population Control

We began this critique by stating that "development assistance" is often used to stabilize Third World economic and political structures favourable to First World interests. Within this overall effort, however, growing populations in the underdeveloped countries have posed a special problem for Western countries, for they represent a destabilizing threat to the current international political status quo. The impetus behind the promotion of global population control strategies since the early 1960s can be seen as a response to this threat. It is useful to quote from Doyals's overview of Western population control efforts:

"Control over the growth of population in the Third World was first seriously advocated in the USA in the 1950's, with campaigns initiated by private organizations such as the Rockefeller Foundation, the International Planned Parenthood Foundation (IPPF) and the Ford Foundation. By the early 1960's, very considerable political support had been engendered, resulting in the active involvement of the United States government.

Indeed policies of this kind became a central pivot in US foreign policy

particularly after the revolution in Cuba... It was considered important to control the size of third world populations both for political reasons — to stave off the threat of revolution among the 'starving millions' — and also to provide (particularly in Latin America) an economic climate as conducive as possible to American investment..

Throughout the 1960's the idea of a population crisis was being further elaborated and fertility control became a major priority in the funding of both research and aid... The giving of all kinds of aid became increasingly tied to the acceptance of an approved family planning programme. * By the late 1960's... the Americans managed to shift a degree of responsibility to international agencies — the United Nations Fund for Population Activities (UNFPA) being set up as an autonomous body in 1969... (Even in 1975, USAID was providing) more than sixty percent of all international assistance for population programmes (though) this multilateral approach helped to diffuse some of the hostility that was developing towards the US in parts of the Third World."¹⁹

In 1976 two-thirds of all U.S. health foreign assistance was allocated to population programmes. And other countries were following similar policies. For example, in 1977 approximately half of Britain's multilateral health aid contributions were devoted to population control.²⁰

As already pointed out in this book, the seriousness of population growth rates in India is uncontested. What is being questioned here is the particular *interpretation* of the "problem" which has been promoted by the Western aid agencies, *and the motives behind such interest*. As George observes, "The mere fact that the rich and powerful have shown such enormous interest in limiting the birth rates of the poor and downtrodden should in itself make us suspicious... Could it be that philanthropists would rather have countries like India tailor their populations to *existing* capacities of agriculture — capacities limited by reactionary land-tenure structures — than see them undertake the thoroughgoing reforms and overhaul of the social system that would be necessary to feed growing populations?"²¹

Multilateral Assistance

It is perhaps unrealistic to expect that individual countries would not shape their foreign aid policies to promote their own national interests. But what about the larger multilateral institutions — institutions such

* We have already seen how food aid in India was conditional upon the Indian government increasing its already substantial effort in Family Planning promotion.

as the World Bank and its affiliated agencies which, because of their enormous control and influence over international finance, hold power of critical significance to the Third World nations in their economic development efforts? Because control over Bank policy is proportional to the financial contributions of individual members, its policies come to reflect the political and economic positions of the First World countries, and especially those of the U.S.

The desire for "political stability" — that is, maintaining the Third World political status quo — is directly reflected in World Bank president Robert McNamara's 1973 address to the Bank governors, a speech in which he introduces the "basic needs" phase of the Bank's rural development activities. McNamara argues that "an increasingly inequitable situation (in the world) will pose a growing threat to political stability" and he asks the First and Third World governments to measure "the risks of reform against the risks of revolution".²² Yet the "reform" envisaged by the Bank is at best a patching-up effort. The basic needs strategy puts "primary emphasis not on redistribution of income and wealth (and therefore, of land)... but rather on increasing productivity of the poor". This lack of emphasis on land reform is necessary, the Bank argues, because "avoiding opposition from powerful and influential sections of the rural community (that is, large landowners) is essential if the Bank's progress is not to be subverted from within."²³

This is a remarkably frank statement of the legitimizing framework of the Bank's activities. It also reveals its priorities: the "Bank's progress" as the focus rather than the "people's progress". In fact, land tenure is not only one of the key issues underlying underdevelopment and low productivity, as we saw in Chapter 7, but also the source of inegalitarian and repressive social structures in many Third World countries — structures which First World business and governments depend upon for maintaining their political leverage and advantageous business contracts.

Furthermore, this "reform" focus of the World Bank is hardly as benign or politically neutral as the above statement would imply, as several analyses of the "integrated rural development" scheme in Colombia reveal. Carty and Smith observe that the Colombian programme was, in fact, "applied specifically to regions with chronic political tensions, militant peasant organizations and sporadic guerilla activity."²⁴ The programme channeled massive technical inputs to middle peasants while ignoring the much larger groups of the landless and minimally landed families. As such, it "circumvents, and is a poor

substitute for land reform." Quoting a Colombian economist, Carty and Smith assert that "the rural development scheme is really trying to create a class of 'little peasant capitalists' to act as a buffer between the impoverished many and the privileged few".²⁵ According to a local peasant leader, the programme "seeks to protect Colombia's large landowners and their export agriculture while co-opting some peasant farmers and undermining their independent organizations."²⁶

That such policy and activities are not restricted to Colombia and Latin America is amply evident in India's World Bank-assisted "basic needs" and "integrated rural development" schemes, for which similar critical analysis is available.²⁷ Carty and Smith conclude: "With an appearance of social progress masking a purpose of social control, the basic needs approach to rural development is the Trojan Horse of today's development aid."

Lappe, in *Aid as Obstacle*, observes that, in practice, "the Bank's programmes favor... countries... such as Brazil, Indonesia and the Philippines where governments are brutally suppressing the efforts of rural people for land." She continues: "(In 1979) only two of the Bank's ten top loan recipients were countries the Bank classifies as 'low income'... Almost one quarter of all World Bank loans in 1979 were allocated to four governments widely recognized as systematic violators of human rights (Brazil, Indonesia, South Korea and the Philippines). Four countries that suffered military takeovers or the imposition of martial law since the early 1970's (Uruguay, Chile, the Philippines and Argentina) received a sevenfold increase in World Bank lending by 1979, while other Bank lending increased only threefold."²⁸

The selective World Bank/IMF lending pattern as an expression of U.S. interests is most clearly reflected in the Central American region. For example, the U.S. has consistently vetoed IMF/World Bank loans to Nicaragua since the popular liberation in 1979, though the IMF approved a major loan to Somoza, the previous dictator, only weeks before his final ouster. And while the new Nicaraguan government remains excluded, the neighbouring El Salvadorean military regime continues to receive regular IMF loans — funds which only serve to prop up the internationally discredited government and prolong the brutal repression in the country.

The overall effect of this lending pattern is clearly recognized by the country which holds maximum influence over the Bank's activities. A U.S. Treasury official candidly points out that "a look at the largest World Bank borrowers in fiscal year 1980 — Brazil, Turkey, Indonesia,

South Korea, Thailand, Colombia and the Philippines — provides a good indication of how this leveraged lending contributes to U.S. security by way of its contribution to growth and material well-being, and thus to stability in vital regions of the world."²⁹

Medical Aid

Leaving aside agriculture and rural development assistance, it might be assumed that at least health-related aid would be more free of self-interested motives. Yet, analysis of bilateral and multilateral health aid programmes suggests otherwise in many cases. Doyal writes: "(Since) the postwar period, the provision of aid has become an important mechanism for the expansion of international markets, both in the health sector and elsewhere... Most medical aid either takes a technological form or is tied to technological inputs. Hence, it encourages a form of health care which will ultimately be of little value to the mass of the Third World inhabitants, but which is extremely profitable to the donor countries and the multinational corporations... The medical (export) industry has long been dominated by the U.S. corporations... (but) in recent years, British based firms too, have become increasingly involved in the production of expensive medical export packages... The medical industry... is expected to become Britain's major source of overseas earnings within the next decade."³⁰

A significant percentage of this medical industry is exported to oil producing states, but as Doyal points out, there is also a considerable market in the poorer Third World countries. Since most of these countries lack foreign exchange to make significant purchases of these commodities, the aid/development agencies of the industrialized countries are now geared to subsidize the initial purchases. In spite of a growing awareness of the inappropriateness of costly technical health services as an approach to the massive problems of societal ill-health in many Third World countries, aid programmes still often promote such spending. White found that technical assistance accounted for about 40% of British government aid in the Health sector up to 1974. This aid "consists largely of training foreign nationals in the U.K., and is strongly biased toward tertiary care — i.e. the acute, high technology hospital sector... Only about 5% of all medical aid is related to primary care — a figure which reflects the fact that the receipt of aid tends to be tied to British goods and services."³¹ Doyal can thus conclude: "While aid forms only a small proportion of health expenditure in most Third World countries, it nevertheless exercises a strong influence over the services provided, reinforcing a pattern of health care which is

increasingly recognized as inappropriate to Third World needs. In the British case, aid is important in promoting the export of British goods and services, in fostering dependence on British scientific expertise and in reinforcing the general dominance of the Western medical paradigm over potentially more effective alternatives."³²

Even the global malaria and smallpox eradication schemes have contained within them some basic economic interests of the contributing Western countries. For example, it was clearly recognized from the beginning that "the elimination of a disease like smallpox... (would) allow nations of the North to discontinue their own elaborate and expensive immunization systems. It has been estimated that the annual savings for the North exceed the total investment made in the WHO's successful Smallpox Eradication Programme".³³ Likewise, U.S. financial support for malaria control is justified by a consultant from the Rockefeller Foundation as follows: "Although malaria is no longer a problem in the U.S., it is of tremendous importance to the American businessman, as 60% of our imports come from and 40% of our exports go to countries in which it (malaria) is a problem... A malaria eradication programme would benefit the U.S. politically and financially."³⁴

Another example of ulterior motives behind international health "aid" is the Cholera Research Laboratory in Bangladesh, an institution established in 1960 by the Southeast Asia Treaty Organization (SEATO). Briscoe, a former CRL employee, has examined the motives behind the activities of this U.S.-controlled organization. With joint U.S.-SEATO funding, the stated objectives of the Laboratory have been to "lift the standards of the people and to bring about economic and social progress to these countries... because... it was the surest method of protecting people from aggression and from subversion which so frequently comes with it."³⁵ Another motive has been the assistance such a research gave to the U.S. war effort in Vietnam: "Between 1963 and 1971, 69% of direct US assistance for Cholera emergencies went, not to the endemic areas of Bangladesh, but to Vietnam." Since the end of the Vietnam war, U.S. interest in cholera control has waned and attention has shifted to population control. Briscoe points out that "the major population control study at the CRL is financed by... USAID and has been used by the head of that office to 'prove' that population growth can be reduced without any change in health conditions, poverty or social justice."³⁶ No doubt USAID officials would deny such a clear statement of motive for their population control activities. Yet such thinking is clearly at the heart of much of the internationally-funded

population control programmes. The implications are extraordinary. Population growth threatens the socio-political status quo of the non-socialist Third World, a status quo which benefits the capitalist nations of the First World. Hence, the frantic need to "prove" that redistributive socio-political change — that is, social justice — is unnecessary(!) for population growth to be controlled.

The Voluntary Agencies

A critique of some of the inadvertent effects of international voluntary agencies has been offered in chapter seven. While generally freer of ulterior interests, and apparently apolitical in character, the voluntary /non-governmental organizations and their projects often serve the political interests of their countries of origin. Examples include U.S. voluntary agencies being used to disseminate Food for Peace donations, among which the CARE distribution of such food to motivate poor women to accept sterilization is particularly striking. Another example is the U.S.-based World Education agency. Kumar and Kidd offer a damning critique of this agency,³⁷ represented in India by Literacy House, showing how its social and ideological interests and values have directly shaped literacy programmes throughout the Third World.

World Education is funded by USAID, the World Bank, some multinational corporations such as General Foods, IBM, Exxon, Carnegie, and various U.S. "charitable" foundations. Kidd and Kumar point out the vast scale of World Education-funded programmes in fifty countries which correspond to the American sphere of influence. They describe its rapid growth in 1968, "after it submitted proposals to the USAID for funds for 'linking literacy programmes and Family Planning education' ".³⁸ The core of the analysis however highlights how this vast network of literacy programmes operates "under the cover of Freirian terminology, (and yet) serves material interests which are directly antithetical to Freire's aim of transforming the structures of oppression in the world". The distorted use of Freirian terms "provide(s) a revolutionary gloss to such projects... (as) a smoke-screen for the real intent of non-formal education which was to legitimate existing social relations in the Third World and between the Third and the industrialized world". The paper traces the charitable origins of World Education and shows how such voluntary "good-intent" has linked with the political-economic interests of the US government aid programmes. "After the collapse of all hopes for business and missionary interest in China (after the 1949 revolution) India offered a fresh and vast ground for experiments

involving corporate charity and welfare democracy",³⁹ which US political interests were soon to take advantage of and exploit.

According to Briscoe, voluntary health schemes in Bangladesh have tended to "contribute to the under-development of health".⁴⁰ Lappe and Collins conclude their broader analysis of U.S. aid with these words: "Most impressive is the difficulty that even the best voluntary agencies have in avoiding... reinforcement of oppressive, elite-controlled economic and political structures... (Indeed) the majority of voluntary agencies, especially the largest, seem to opt to collaborate directly with foreign governments, including some of the world's most repressive ones."⁴¹ All these studies thus suggest that much of the activities of even the voluntary development agencies, unwittingly or otherwise, serve the political, ideological and economic interests of the industrialized Western countries.

Aid As Diversion

This brings us to a final step in this critique of the motives behind development assistance. It is true that there have been many examples of "technical" assistance, such as the Smallpox Eradication Programme, which have directly benefitted Third World peoples, though it would seem that such assistance represents only a small proportion of the total. A number of recent analyses however indicate that the renewed interest by First World governments in maintaining or even increasing traditional "aid" programmes is in itself an effort to deflect attention away from the much more important "North-South" issues — as expressed by Third World countries in their demands for a New International Economic Order (NIEO). Such NIEO proposals include reform of the structures of unequal rates of exchange between underdeveloped and industrialized countries, changes in out-dated and biased tariff agreements, and basic restructuring of control over international financial institutions. The importance and legitimacy of such proposals is clear, as one single example reveals: deteriorating terms of trade between Third World and industrialized countries over the past twenty years has meant that the prices of commodities exported by Third World non-oil producing countries have fallen by more than 40% relative to the price of imports from industrialized countries.⁴² In other words, the international economic structures now in place prescribe and guarantee a rapidly widening gap between the technology-rich industrialised countries and most countries of the Third World.

Yet demands from the underdeveloped countries for changes in international trade and financial structures remain essentially ignored,

and as many critics suggest, actively submerged within the rhetoric of "aid" programmes from the industrialized countries — even though it is clear that the benefits of such "aid", whether granted for ulterior motives or not cannot begin to offset the impoverishing effects of unequal international exchange and trade relations.

It does not therefore seem too strong to conclude, as do Carty and Smith, that the current revival of "aid" promises by the industrialized countries of the West stems from the following four motives:

- "1. Providing short-term relief for Third World financial crises.
2. silencing some of the Third World demands for structural reforms (as embodied by the NIEO proposals) by offering instead more aid and only minor adjustments to international institutions.
3. building a new network of political alliances to support the West in its renewed conflict with the East.
4. helping northern economies export their way out of the economic slump."⁴³

NOTES

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THE AUTHOR

Sheila Zurbrigg is a Canadian doctor who became interested in rural health and health care through work with the WHO in the Indian Smallpox Eradication Programme in 1974-75. This experience involved working with the staff of a large number of Primary Health Centres throughout several districts of the State of U.P. Between 1975-79, the author helped to develop a rural health programme based on the concept of "Village Health Workers", in southern Tamil Nadu. In spite of the technical successes of these health programmes, she has subsequently sought to place her rural experiences within a broader social and political perspective. Though holding degrees in Tropical Medicine and Public Health, she readily admits that her most useful education came from observing the lives of labouring village families in their daily struggle against disease and hunger.